Health and welfare
services in Canada
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PUBLIC HEALTH AND WELFARE SERVICES IN CANADA

A Report Prepared for the
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This booklet deals only with programs on which the Research and Statistics Division reports for the Canada Year Book. Information on Unemployment Insurance, programs for War Veterans and other data prepared by other agencies is therefore not included.

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PUBLIC HEALTH AND WELFARE SERVICES IN CANADA

Introduction

Canada's health and welfare services have undergone a constant development and expansion during the post war years. Generally high levels of prosperity, strongly growing trends toward urbanization and new advances in welfare, and in health concepts and knowledge, have all contributed to their rapid growth.

Welfare as well as preventive, diagnostic and curative health and rehabilitation services, have become available to most areas of the country in some degree. The federal-provincial-municipal partnership in health matters forms a flexible and effective bulwark for the medical and allied professions that has been stimulated and co-ordinated through the National Health Grant Program. On the welfare side the major federal, federal-provincial and provincial income maintenance programs provide basic protection to the individual against the hazards of age, disability, unemployment or other inability to earn and, at the same time, substantially assist the municipality in providing for persons who would at one time have been a local responsibility. Generally well developed systems of hospitals provide facilities in settled areas of the provinces. The federal Indian and Northern Health Service, through hospitals and nursing stations, brings services to the widely scattered and often nomadic population of the north. Cost to the individual as a barrier to obtaining necessary hospital care is being eliminated through the provincial hospital insurance programs developed under the Hospital Insurance and Diagnostic Services Act of 1957.

Development in the sciences related to medicine, improved health services and raised nutritional and other standards have all contributed to favourable health conditions. Canada has a continuing high birth rate and a declining death rate. The former was 27.6 in 1958, the latter 7.9.

Progress against the contagious diseases continues to throw new emphasis on the problems presented by the chronic groups and the disabilities of the later years. Heart and hypertensive disease, arthritis and rheumatism are among the leading causes of disability, the various disorders affecting the nervous system give cause for concern. Residual disability from stroke, Parkinson's disease, epilepsy, multiple sclerosis all account for large numbers of disabled persons. The death rate for lung cancer continues to increase and cause controversy. Mental illness remains a major problem. Accident rates and especially those for traffic accidents, constitute a steady and tragic problem especially as they affect children.

Canada shares today the world-wide concern for the hazards of radiation, from medical and industrial causes as well as from fallout.

Progress in the welfare field has also been so substantial as to emphasize remaining problems, some of which are of considerable magnitude. Rapid urbanization, increasing numbers of older persons population, large scale immigration, are among the new forces to which social approaches must be developed.

The growth of the industrial community in Canada has however been associated with a marked improvement in the general standard of living. Higher real income has permitted better levels of nutrition and better housing; since the end of the war, more than a million new housing units have been provided. Improved working conditions and shorter working hours have benefitted the industrial worker. The last decade has also seen the extension of urban technical and health services to the rural population of the country, so that many of the improvements in the national standard of life have become shared more equally between the urban and rural population.

PART I - FEDERAL PROVINCIAL AND LOCAL HEALTH SERVICES

Provincial governments bear the major responsibility for health services in Canada, with the municipality often assuming considerable authority over matters delegated to it by provincial legislation. The federal government has jurisdiction over a number of health matters and all levels of government are aided and supported by the network of voluntary effort which has developed through the years.

Subsection 1 -- Federal Health Activities

The Department of National Health and Welfare is the chief federal agency in health matters, with important treatment programs also being administered by the Departments of Veterans Affairs and National Defence. The Dominion Bureau of Statistics is responsible for the compilation of health statistics, the National Research Council and the Defence Research Board administer medical research programs, and the Department of Agriculture has certain health responsibilities connected with food production.

The Department of National Health and Welfare controls food and drugs including narcotics, operates quarantine and immigration medical services, carries out international health obligations, and provides health services to Indians, Eskimos and other special groups. It serves in an advisory and co-ordinating capacity to the provinces and administers grants to provincial health and national voluntary agencies. Administration of federal aspects of the hospital insurance and National Health Grant Program have become a major activity in the last decade.

The Department advises on the visual eligibility of applicants for blindness allowances and co-operates with the provinces in the provision of surgical or remedial treatment for recipients of the allowances. Under the Public Works Health Act, supervision of health conditions is provided for persons employed on federal public works. Other programs of health or medical supervision and couselling are provided to the federal Civil Service, and to the Department of Transport in all matters pertaining to the safety, health and comfort of air crew and passengers.

Co-ordination with the provinces on health matters is facilitated by the Dominion Council of Health, the principal advisory agency to the Minister of National Health and Welfare. Its membership includes the Deputy Minister of National Health, who acts as chairman, the chief health officer of each province, and five appointees of the Governor in Council representing the universities, labour, agriculture and French- and English-speaking women's organizations. The Council meets semi-annually. Federal-provincial technical advisory committees of the Council deal with specific aspects of public health.

National Health Grant Program. - The National Health Grant Program, inaugurated in 1948, initially made ten federal grants available to the provinces for the development and strengthening of public health and hospital services. Nine are continuing grants: the Hospital Construction, Professional Training, General Public Health, Public Health Research, Mental Health, Tuberculosis Control, Cancer Control, Venereal Disease Control, and Crippled Children Grants. A Health Survey Grant lapsed in 1953, following completion of provincial health surveys. In 1953, after a review of the first five years of the Program, three new grants were established: Child and Maternal Health, Medical Rehabilitation and Laboratory and Radiological Services.

In 1958, federal assistance under the Hospital Construction Grant was increased to $2000 per hospital bed, whether active treatment,chronic, mental or tuberculosis, doubled the previous grant for active treatment beds. In addition, funds were made available to meet up to one-third of the cost of approved alterations and renovations to existing facilities, with the provinces at least matching federal contributions. There are also matching requirements under the Cancer and Venereal Disease Grants and in the case of services (as distinct from equipment and training of personnel) in those for Medical Rehabilitation and Laboratory and Radiological Services.

Up to March 31, 1959, aid for construction was approved for 77,053 beds, 10,012 bassinets, 15,493 nurses beds, 330 internes beds, and space in community health centres and laboratories exceeding 10,650 bed equivalents. Approximately 23,000 health workers had been trained or were undergoing special training and over 6,200 health workers had been employed with federal grant assistance.

The proportion of the total grants appropriation paid out to the provinces has steadily increased; payments in 1958-59 totalled $45,859,381 or 84 per cent of the amount available while the average utilization during eleven years of the program was 72 per cent.

In March 1960 the Minister of National Health and Welfare, in testimony before the Special Committee on Estimates of the House of Commons, announced that the amount made available under the General Public Health Grant would be raised by nearly $5.5 million and the Medical Rehabilitation Grant to more than $2.6 million. At the same time he announced that the Laboratory and Radiological Services and Venereal Disease Control Grants would be absorbed into the General Public Health Grant, and the Crippled Children Grant into that for Medical Rehabilitation. The Mental Health Grant would be increased by $1.5 million and those for Professional Training and Public Health Research to a total of $1.74 million each. At the same time the amounts available under the Tuberculosis and Cancer Control and Child and Maternal Health Grants were to be decreased. This modification of the programme was decided upon, after consultation with the provincial health departments and other agencies concerned, because projects formerly dealt with under the Laboratory and Radiological Services Grant are increasingly being included with the hospital insurance scheme and because it was believed that a more effective co-ordination with other local health programmes could be achieved if venereal disease problems could be dealt with under the broader terms of reference of the General Public Health Grant. Similarly it was believed that more flexibility could be given to rehabilitation services under the new arrangement.

Table 1 -- Amounts Available and Amounts and Percentages Expended under the National Health Program by Grant, for the Eleven-Year Period Ended March 31, 1959, and for the Year Ended March 31, 1959.

Grant	1948-59 Period			Year Ended March 31, 1959		
	Amount Available	Amount(1) Expended	Percentage Expended	Amount Available	Amount(1) Expended	Percentage Expended
	$	$		$	$	
ncer Control	39,466,858	25,742,030	65	3,598,795	3,378,688	93
ippled Children	5,687,830	3,928,109	69	519,898	413,228	79
neral Public Health	76,036,601	48,837,513	64	8,294,500	7,231,668	87
alth Survey	645,180	540,960	83	-	-	-
spital Construction	118,847,892	101,275,181	85	17,367,320	16,827,224	96
ntal Health	67,016,015	49,602,641	74	7,234,868	6,795,471	93
cfessional Training	5,662,644	5,782,695	102	516,300	617,425	119
blic Health Research	4,614,148	3,859,415	83	512,900	464,530	90
bercul sis Control	44,305,331	41,232,888	93	4,239,531	3,781,532	89
enereal Disease Control	5,450,237	4,704,914	86	518,099	443,181	85
ild and Maternal Health	9,500,000	5,543,381	58	2,000,000	1,700,420	85
boratory and Radiological Services	38,880,300	11,437,977	29	8,294,500	3,514,401	42
edical Rehabilitation	5,500,000	2,343,351	42	1,000,000	619,613	69
Totals	421,613,036	304,831,055	72	54,096,711	45,859,381	84

(1) Expenditures may exceed 100 per cent of amounts available, through transfer of unexpended funds from one grant to another.

Hospital Insurance. - The Hospital Insurance and Diagnostic Services Act of 1957 provides enabling legislation under which federal grants-in-aid are made available to the provinces to assist in operating publicly administered insurance plans for general hospital care. The method of financing and administering plans, as well as the type of services offered above the minimum stipulated in the Act, is a provincial matter.

Under the financial formula, the federal government contributes about one-half of the agregate shareable costs of the hospital insurance plans. In the individual provinces, however, the federal share varies since each participating province receives 25 per cent of the national per capita cost of hospital services plus 25 per cent of its own provincial per capita cost, multiplied by the population covered.

The Act enumerates the basic range of services mandatory for any provincial scheme receiving federal support. Each participating province is required to make specified benefits universally available to its population. The total days of care provided may not be limited and must include basic public ward and other in-patient service normally associated with the operation of a hospital, together with certain diagnostic aids for in-patients and, on a permissive basis, for out-patients. Services may be provided in chronic as well as active treatment hospitals, but legislation specifically excludes care in tuberculosis sanatoria, mental hospitals and institutions for custodial care. Capital costs are also specifically excluded from shareable costs. Thus the federal Act is set up to assist in provision of an insurance system for basic general hospital services available under uniform terms and conditions to the entire provincial population. (See also descriptions of provincial plans in Section dealing with provincial services.)

Food and Drug Control. - The Food and Drugs, Proprietary or Patent Medicine, and Opium and Narcotic Drug Acts govern the safety, purity and quality as well as the labelling and advertising of all goods, drugs, therapeutic devices and cosmetics. Standards of safety and purity are maintained through constant and widespread inspection and laboratory research. In the central Food and Drugs laboratory, standards governing ingredients are formulated and methods of analysis developed. Special research is carried on to establish the safety of new products. Several panels of experts advise on technical and medical problems.

Regulation of the domestic supply of narcotic drugs is maintained through a system of licensed distributors and reports of all stocks subsequently sold or dispensed. Enforcement of the provisions concerning illicit traffic is carried out in collaboration with the Royal Canadian Mounted Police.

Indian and Northern Health Services. - The Department of National Health and Welfare makes available public health, medical and hospital services to about 174,000 Indians and 11,000 Eskimos. The program relative to Indians is administered by the Directorate of Indian and Northern Health Services in collaboration with the Department of Citizenship and Immigration, and for Eskimos with the Department of Northern Affairs and National Resources.

Services are provided directly to about 2,000 small scattered groups through a network of 17 hospitals, 41 nursing stations and about 80 other health centres staffed by full-time medical officers, graduate nurses, and other health personnel. In areas where departmental staff or facilities are not located, private practitioners and provincial or community health agencies provide care in return for fees for service, payment of per diem rates or through other arrangements. Special emphasis is placed on tuberculosis control through health education, field X-ray surveys, BCG vaccination and early treatment in sanatoria.

Immigrants. - The Department of National Health and Welfare advised on the administration of sections of the Immigration Act dealing with health, and conducts in Canada and other countries the medical examination of applicants for immigration. It also provides necessary health care for immigrants who become ill en route to their destination or while awaiting employment. Further assistance in the provision of hospital and medical services is available to indigent immigrants during their first year in Canada, either from the Federal Government or from the province with federal sharing of costs.

As a part of its contribution to International Refugee year, arrangements were made by Canada for the admission of a number of refugee families with one or more members suffering from tuberculosis.

Quarantine. - Under the authority of the Quarantine Act, all vessels, aircraft and other conveyances together with their crew members and passengers arriving in Canada from foreign countries are inspected by quarantine officers to detect and correct conditions that could lead to the entry and spread of quarantinable diseases in Canada. Fully organized quarantine stations are located at all major seaports and airports.

Under the provisions of the Leprosy Act, modern facilities for the diagnosis and treatment of leprosy are provided at Tracadie, New Brunswick, for the small number of persons in Canada suffering from this disease.

Sick Mariners. - Under the authority of Part V of the Canada Shipping Act, the Department of National Health and Welfare provides prepaid health services for crew members of foreign-going ships arriving in Canada and Canadian coastal vessels in interprovincial trade; crew members of Canadian fishing and government vessels may participate on an elective basis. Hospital care of crew members resident in any of the provinces which have hospital insurance plans in operation is now the responsibility of the provincial hospital authority concerned. The total number of crew members on vessels paying sick mariners dues in 1958 was about 126,000.

Health Research. - The National Research Council, the Department of National Health and Welfare, the Defence Research Board and the Department of Veterans Affairs all administer grants-in-aid of medical, public health or socio-economic health research. The latter three also conduct intramural research. Federal funds amount to about 50 p.c. of overall expenditure on medical research in Canada.

The Division of Medical Research of the National Research Council, set up in 1946, offers grants chiefly for fundamental studies in basic medical science. In 1959-60 these totalled about $1,650,000 besides an additional $300,000 for fellowships and associateships.

The Department of National Health and Welfare supports both intramural and extramural research, chiefly of an applied nature, to an amount of about $3,500,000 annually. Grant assistance comes from the Public Health Research Grant, with substantial amounts provided from other grants such as those for mental health, cancer control and general public health. Departmental public health research is conducted in the laboratories of the Food and Drug Directorate, the Laboratory of Hygiene, the Occupational Health Division and the Nutrition Division, as well as by the Epidemiology and Dental Health Divisions. Research in both the health and welfare fields is carried on by the Research and Statistics Division, which collects, analyzes and evaluates data on health and welfare matters, develops methods to assist in solving technical and administrative problems, and provides research and consultant services to other Divisions of the Department and other agencies in Canada and abroad.

The Defence Research Board carries on intramural research and provides grants-in-aid for investigations related to health problems concerned with national defence.

The Department of Veterans Affairs is concerned primarily with clinical research in its own hospitals, with emphasis at the present time on the problems associated with the aging process.

The Dominion Bureau of Statistics collects and publishes reports on vital and other health statistics and hospital data, and carries out surveys on health matters.

International Health. - Canada has been a signatory to certain international agreements and conventions and is a member of and co-operates with W.H.O. and other international agencies concerned with health.

To carry out this country's obligations under the International Sanitary Conventions, the Department of National Health and Welfare maintains quarantine measures for ships and aircraft entering Canadian ports and provides accommodation and necessary medical care for persons arriving in Canada who require quarantine.

The Department is responsible for the enforcement of requirements governing the handling and shipping of shellfish under the International Shellfish Agreement between Canada and the United States and, at the request of the International Joint Commission, participates in studies connected with control of pollution of boundary waters between Canada and the United States and with problems caused by atmospheric pollution. Other international health responsibilities include the custody and distribution of biological, vitamin and hormone standards for the World Health Organization, certain duties in connection with the Commission on Narcotic Drugs of the United Nations and the provision of technical assistance to W.H.O. and other specialized agencies of the United Nations carrying out programs related to health.

Subsection 2. - Provincial and Local Health Services

Provincial and local health services may be grouped in several broad categories. For purposes of their description in this report the following categories have been used: general public health services, primarily of a preventive nature; services for specific diseases or disabilities combining prevention and treatment; services related to general medical and hospital care; and rehabilitation services for disabled persons.

General Public Health Services. - Provincial and local government co-operate closely in providing community public health services. The autonomy of the provinces and their social, economic and geographic diversity make for some variety in legislative provisions, in financial arrangements, and in the detailed division of functions between provincial health departments and local and voluntary agencies. Each province, however, now offers all or nearly all of a basic range of public health services which include environmental sanitation, communicable disease control, child and maternal hygiene, health education, vital statistics, public health laboratories, occupational health, dental public health and nutrition services.

Environmental Sanitation. - The control of environmental hazards to health, one of the oldest forms of public health activity, is a function of specialized environmental sanitation or public health engineering divisions in each provincial health department. Programs are concerned primarily with the maintenance of safe water supplies, supervision of sewage disposal systems, milk sanitation and control of general sanitary conditions in public areas, the most extensive sanitary facilities being located, of course, in industrial and urban centres. Provincial and municipal sanitary engineers set standards, formulate policies and regulations, and provide technical assistance to local authorities. The intensity of this type of preventive supervision and control varies from province to province and within the province, but basic programs are similar.

Occupational Health. - Services designed to prevent accidents and occupational diseases and to maintain the health of employees are the common concern of provincial health departments, labour departments, workmen's compensation boards, and industry management. Provincial agencies regulate working conditions and offer consultation and educational services to industry. All provinces have on their statute books legislation (Factory Acts, Shop Acts, Mines Acts, Workmen's Compensation Acts) setting health safety standards for employers.

Communicable Disease Control. - The control of communicable disease has been intimately connected with the beginnings and development of public health measures and concepts. Separate divisions of epidemiology or communicable disease control exist in the six larger provinces; in the Atlantic Provinces these functions are handled by a provincial medical health officer. Local health authorities undertake case-finding and diagnostic services in co-operation with public health laboratories, carry out epidemiological investigations and often participate in tuberculosis and venereal disease control measures.

Maternal and Child Health.- Services for mothers and children are largely decentralized through local units and departments, but most provinces maintain separate divisions or employ consultants to promote better standards and to give technical assistance. Public health nurses have a prominent place in this work which may include prenatal education, provisions for delivery and care of the newborn in remote areas, home visits, child health clinics and school health services.

Nutrition. - Services include technical guidance, education, consultation and research. In some provinces school lunch programs are also sponsored and dietary supplements distributed. Five provinces have special nutrition divisions; elsewhere nutritionists serve in other divisions of the health department.

Health Education. - In most provinces experience has demonstrated the need for a professional full-time "health educator" as a member of the public health team. Nine provinces have separate divisions or units to co-ordinate the dissemination of health information through all available media.

Public Health Laboratories. - The public health laboratory, an essential facility in the protection of community health and the control of infectious diseases, was one of the earliest provincial services developed to assist local public health departments. Work performed includes bacteriological examination of water, milk and food samples, the examination of specimens for diagnosis of communicable disease and pathological special services. Each province maintains a central public health laboratory and most provinces have established additional branch laboratories, Recent trends in some provinces include efforts to co-ordinate public health and hospital laboratory services, special measures to bring laboratory facilities to rural areas, and devices to reduce the direct cost of clinical laboratory procedures to the individual.

Mental Health. - Major developments in provincial mental health programs concern the expanding and modernizing of mental hospitals, the training of various kinds of psychiatric personnel and the extension of community mental health services outside mental hospitals. Assistance to patients in securing employment and in social adjustment following discharge from mental hospitals - a relatively new field of rehabilitation - is being promoted by voluntary groups and government agencies in several provinces.

At the end of 1958, Canada's mental hospitals, exclusive of psychiatric units, reported a total of 73,224 patients; of these 66,263 were in hospital and the remainder on probation or receiving supervised care in boarding homes. Despite a growing rate of discharges, the daily average number of patients has continued to rise each year. Construction of new hospital accommodation continues and approximately 17,000 mental beds have been added since 1948. While there is still an acute shortage of mental hospital accommodation, there has been some reduction in overcrowding. The occupancy rate has declined from 128 patients for each 100 rated beds in 1948 to 114.3 patients in 1958, despite a continuous increase in the average daily population.

With the exception of the municipally owned local institutions in Nova Scotia and hospitals in Quebec that operate under religious or lay auspices, most mental hospitals are administered by provincial authorities. A great part of the cost is borne by the provincial governments, though patients whose relatives can afford to contribute may be charged for care in some provinces. Newfoundland and Saskatchewan provide complete free care while Manitoba assumes a minimum maintenance cost for all patients. Nova Scotia's provincial hospital supplies free care to patients requiring active treatment. In Ontario and Prince Edward Island mental hospital treatment is included in the hospital care insurance plan.

Most public mental hospitals provide care and treatment for all types of mental illness; as facilities expand, it is becoming possible to segregate under intensive treatment from those receiving long-term care. Some provinces maintain separate accommodation for certain categories of the mentally ill. For example, in British Columbia and Alberta, homes for the senile aged are an integral part of the mental hospital system. Ontario and Quebec have separate hospitals for epileptics. Seven provinces operate schools for residential treatment and education of mentally defective persons and one of the remaining provinces, New Brunswick, enacted legislation in 1958 authorizing the government to support the maintenance of mentally retarded children in approved homes. During the past decade, increasing numbers of local day classes, usually sponsored by parent organizations, have offered training opportunities for mentally deficient children in the community.

As the needs of patients are more fully understood and better methods of treatment develop, the daily routine of the mental patient is becoming less restrictive, as is shown in the increasing number of persons coming voluntarily for treatment. In 1958 these comprised 31 p.c. of all mental hospital first admissions and 72 p.c. of admissions in the same category, to the psychiatric hospitals or short-stay centres. Custodial care and locked doors have given way to an encouraging extent to open wards where patients may have unrestricted access to grounds, occupational and recreational areas.

Persons engaged in the treatment of the mentally ill are the largest single group employed by provincial governments. Although an acute shortage of professional personnel still exists, an expanded program of training is now in operation.

One of the greatest changes in the past decade has been in the extension of community mental health services outside mental hospitals. General hospitals have expanded their psychiatric services in both in-patient and out-patient departments. About 30 general hospitals have organized units where psychiatric treatment is provided by professional trained staffs. First admissions to these units in 1958 were reported to be 8,855. Out-patient clinics where mental illness may be treated at an early stage and guidance services given to children and parents also play an important part in the treatment of mental illness outside mental hospitals. Less than 20 mental health clinics existed in 1948. Groups active in the subsequent large expansion include provincial health departments, municipalities or health units, mental hospitals, general and allied special hospitals, school boards and voluntary organizations.

Day and night care centres, another departure from the traditional form of custodial care, developed first in Montreal a decade ago as part of the psychiatric service of two large general hospitals. Similar centres, admitting patients on a nine-to-five basis or in the evening after work have now been opened at St. John's, Newfoundland, Toronto and Cobourg, Ontario, and Burnaby, British Columbia.

Cerebral Palsy. - Cerebral palsied children in most larger centres are able to attend out-patient and training centres, many of which were organized by parent groups. A number of general and children's hospitals have also established assessment and treatment facilities for cerebral palsied children. Buses to transport children to day centres and hospital clinics in most communities are provided and operated by local service clubs or provincial crippled children societies. Attendance fees are usually nominal with financial support of the centres coming from local voluntary contributions, provincial governments and federal health grants. Training and employment programs for young adult cerebral palsied persons are also being developed in a few cities.

Tuberculosis. - Despite greatly reduced mortality from tuberculosis and evidence of some lowering in incidence, the number of cases discovered through provincial detection programs indicates it to be still a public health problem. Case-finding efforts are being focussed increasingly on selected groups particularly vulnerable to tuberculosis, with diminishing emphasis on mass x-ray surveys and greater attention to tuberculin tests as a means of pinpointing infected persons. The work of case-finding is supported substantially by voluntary campaigns conducted by the Canadian Tuberculosis Association.

Sanatoria treatment is free in Newfoundland, Nova Scotia, New Brunswick, Manitoba, Saskatchewan and Alberta, and is included in the hospital insurance benefits which came into effect in Ontario and Prince Edward Island. Even in those provinces where a charge for sanatoria care may be made, the amount collected from paying patients is a very small percentage of total costs.

The number of beds set up in sanatoria and in tuberculosis units of general hospitals declined from a peak of 18,977 in 1953 to 14,655 in 1958. This decline in bed use has resulted from such factors as a decrease in the number of admissions, detection of cases in earlier stages of the disease, and improved treatment methods by drugs and surgery. Provision has been made in several provinces to furnish drugs to patients for home treatment. Facilities for the vocational rehabilitation of discharged patients have been developed in all provinces, and increasing numbers are being re-established in suitable employment.

Cancer. - Health departments and lay and professional groups working for the control of cancer have been concerned mainly with four aspects of the problem - diagnosis, treatment, research and public education. In the detection and treatment of cancer, specialized medicine, hospital services and an expanding public health program are closely related. There are programs operating under health departments in four provinces; an equal number have provincially supported cancer agencies or commissions. These sponsor the work of diagnosis and treatment in special clinics located usually within the larger general hospitals. Under the provincial hospital insurance plans, the benefits pertaining to in-patient care in the treatment of cancer are essentially similar in nine provinces, and include such special services as diagnostic radiology, laboratory tests and radiotherapy. In at least five provinces these benefits also apply to out-patients. In others, the previous pattern of services to out-patients - that of assessing costs of treatment in relation to ability to pay - is still in effect. Comprehensive free medical programs for cancer patients, which have long operated in Saskatchewan and Alberta, continue unchanged.

Poliomyelitis. - Through agreements with the federal government, all provincial health departments have made Salk vaccine available for free inoculation of children and are encouraging older age groups to avail themselves of the protection of this vaccine.

During 1959, the incidence of paralytic poliomyelitis rose in all provinces to its highest level since vaccination began, while the national total was the second largest in the last 10 years. By far, the greatest proportion of cases occurred among unvaccinated persons. Very few who had received the prescribed number of inoculations contracted the disease.

Previously existing programs offering free standard ward hospital care to poliomyelitis patients have now become incorporated in the federal-provincial hospital insurance schemes. In the provision of restorative services through remedial surgery, physiotherapy and hydrotherapy and the aid of prosthetic appliances, both provincial departments of health and voluntary societies have a part.

Post-poliomyelitic patients may receive vocational training under provincial rehabilitation schemes; boards of education operate special classes for physically handicapped children.

Dental Health. - All provincial health departments have dental health divisions which administer dental programs, varying under local conditions but directed almost entirely to the care of children. Training of dentists in public health, the operation of children's preventive and treatment clinics, and health education are being undertaken in all provinces. Water fluoridation projects, involving an overall total of more than a million people, are in operation in seven provinces.

In four provinces free clinical care is provided for children in remote rural areas by the use of mobile units. One province uses two railway-coach dental clinics to serve remote areas. A successful locally-sponsored plan in which the cost of dental services for children is shared between the local community and the provincial health department is in operation in more than 70 communities in British Columbia; the sponsoring group decides whether registration for treatment may be free or on the payment of a nominal sum.

Venereal Disease. - Free diagnostic and treatment services are available in all provinces but government clinics are being increasingly superseded by private physicians who are supplied with free drugs and reimbursed for treatment of indigents on a fee-for-services basis.

Alcoholism. - Ontario, Manitoba, Alberta and British Columbia carry out research and education programs and operate centres for treatment supported largely by public funds. Ontario, Saskatchewan and Alberta also have rehabilitation programs for alcoholic inmates of reform institutions. Recent legislation in Newfoundland and Nova Scotia authorizes the setting up of similar agencies to initiate research and education studies.

Other Diseases or Disabilities. - Services for a number of chronic disabilities, such as heart disease, arthritis, diabetes, visual and auditory impairments and paraplegia are being developed largely by voluntary agencies, assisted by federal and provincial funds. A brief description of the programs of some of these agencies is given in Part III, National Voluntary Health and Welfare Activities.

Health Statistics. - Statistical information on the health of Canadians is at present limited to the well established and highly standardized mortality, communicable disease and institutional statistics series, all of which have been available for a long period. As compared with these records, other national health statistics are still in an early development stage. So far the only source of information on general illness, health services and personal expenditure for health care is the Canadian Sickness Survey of 1950-51. Other projects deal with specific health problems or selected groups of the population and much of the statistical information is available from provincial and other health sources.

Hospital Care. - The four provinces with hospital insurance plans in operation prior to the passing of the federal Hospital Insurance and Diagnostic Services Act of 1957 - Newfoundland, Saskatchewan, Alberta and British Columbia - amended their programs to bring them into conformity with the federal Act from July 1, 1958. Manitoba commenced its plan on the same date. The Nova Scotia and Ontario plans became operative on January 1, 1959, that of New Brunswick on July 1, 1959 and Prince Edward Island on October 1, 1959. An agreement was signed with the Northwest Territories on March 1960, to become effective 1st April 1960.

All plans, in conformity with the federal Act, provide in-patient services to all insured residents of the province under uniform terms and conditions. In-patient services include standard ward accommodation and necessary nursing care, laboratory, radiological and other diagnostic procedures, together with necessary interpretations, the use of operating and case rooms, anaesthetics, specified drugs while in hospital, and other ancillary hospital services. The federal Act also permits federal sharing in the costs of a range of permissive out-patient services; the extent of participation in out-patient services varies from province to province.

Public Medical Care. - Public medical care programs for the general population exist in three provinces, but are limited to residents of particular areas. Approximately one-half of Newfoundland's population receive physician's services at home or in hospital under the provincialy-administered Cottage Hospital Plan which is financed in part on a premium basis. Medical indigents not under the Plan may also receive care at provincial expense. In addition, all Newfoundland children under the age of sixteen years are entitled to free medical and surgical care in hospital. In Manitoba and Saskatchewan, locally-operated municipal-doctor programs cover about 30,000 and 167,000 persons respectively. The Swift Current Health Region in Saskatchewan operates a comprehensive prepaid medical-dental care scheme for about 50,000 persons. These latter programs are subsidized to some extent by provincial health departments.

Nova Scotia, Ontario, Saskatchewan, Alberta and British Columbia provide health service programs for social assistance recipients, although Nova Scotia covers only Mother's Allowance recipients and their dependents, and Blindness Allowance recipients, and in Saskatchewan, Old Age Assistance recipients are the responsibility of the municipality of residence. Manitoba is introducing services. Indigent persons not covered by these programs, as well as indigents in other provinces, may receive necessary care from the municipality of residence. In general, where costs are assumed by the municipality, there is some form of cost-sharing arrangement with the provincial government.

Under the Ontario program the major medical services offered are physician's care in the home and office, including certain minor surgical procedures and pre- and post-natal care. Since January 1, 1959, basic dental care has been made available to the children of Mother's Allowance recipients. In addition to these medical services, Nova Scotia provides both major and minor surgical and obstetrical services and medical attendance in hospital. The programs in Saskatchewan, Alberta and Brtish Columbia give complete medical care in the home, office and hospital, including surgical and obstetrical services, specified prescription drugs (except in Alberta, and with a dollar limitation in Saskatchewan) and dental and optical care, sometimes only on authorization and/or with dollar limits. All of these plans are completely provincially financed, except in British Columbia where costs are shared on a 90/10 basis, with the municipalities assuming their share on a proportionate population basis, and in Ontario where per capita contributions towards the cost of medical services for the assistance group are shared on an 80/20 basis with the municipality of residence.

<u>Rehabilitation Services</u>. - Expansion of rehabilitation services in all provinces indicates growing success in prevention and control of many disabling conditions, and broader understanding of the needs of handicapped persons. Following the earlier rehabilitation programs organized for injured workers, disabled war veterans and such groups as the blind and the tuberculous, there has been continued progress in the development of services for other disability groups and special medical, vocational, educational and social services for the handicapped. Recent advances in rehabilitation have given more emphasis to extending comprehensive services to all handicapped, regardless of disability, and to strengthening national, provincial and community bodies concerned with planning and co-ordination. The broadening scope of rehabilitation programs and movement towards integration of the numerous specialized services are exemplified by the liaison developed

between two of the large national voluntary agencies, the Canadian Council for Crippled Children and Adults and the Canadian Foundation for Poliomyelitis and Rehabilitation, as well as by the steady growth of the official provincial rehabilitation programs and the development of co-ordinated community services for the handicapped. Concurrently there has been more attention given to improving treatment and social services for the mentally ill, mentally retarded children, alcoholics, cerebral palsied children and other disability groups.

Rehabilitation services for persons handicapped by physical or mental defects are organized under voluntary and public auspices as part of general health, welfare or educational programs, and also by specialized agencies which provide one or more rehabilitation services. In many of the larger cities, these facilities include hospital physical medicine and rehabilitation departments and special clinics for particular disabilities, separate rehabilitation centres, sheltered workshops, vocational counselling, training and job placement agencies, and special classes, schools and other combined treatment and educational centres for handicapped children. Home care services such as home nursing, physical and occupational therapy and housekeeping services, employment of the homebound and recreational services have been started by a few agencies, but their coverage is generally limited.

The main elements of the nation-wide rehabilitation program, introduced in 1953, are supported by joint federal-provincial programs for the co-ordination of rehabilitation services, the vocational training of disabled persons, and the national health grants designated for the extension of medical rehabilitation and crippled children's services and for the rehabilitation of the mentally ill or deficient, the tuberculous and other chronically ill. Vocational assessment and counselling of the handicapped is provided by rehabilitation officers attached to the provincial rehabilitation services and by some of the other rehabilitation agencies and centres. Medical rehabilitation services are made available through the provincial public assistance medical care schemes, hospital insurance plans, public health services, the voluntary agencies and various Health Grant projects. The main responsibility for job placement of persons with occupational handicaps is carried by about 140 special placements officers located in the larger National Employment Service offices across the country, although some rehabilitation agencies also do placement work, especially of the severely handicapped. The federal government also provides direct services through the programs administered by the Department of Veterans Affairs, which operates special centres for the treatment of chronically ill and aging veterans, by the Department of Citizenship and Immigration for physically and socially handicapped Indians and by the Department of Northern Affairs for the resettlement of Eskimos suffering from disability.

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4.60

In the 1958-59 fiscal year, federal-provincial expenditures shared under the co-ordination of Rehabilitation of Disabled Persons Agreements administered by the Department of Labour, increased to $195,000. The cost of support of 1,174 disabled persons reported as rehabilitated was $1,232,000 during the year prior to acceptance as compared with estimated annual earnings of $2,219,300 after placement in jobs. The total vocational training expenditures under Schedule "R" for disabled persons of the Special Vocational Training Projects Agreements, also a matching grant administered by the Department of Labour, rose to $533,000 for the training of 1,251 individuals enrolled in a wide range of vocational courses during 1958-59. The number of special placements made by the National Employment Service of the handicapped who required assistance in finding work decreased to 14,845 in this year.

Projects under the Medical Rehabilitation and Crippled Children Grants, a portion of these funds being on a matching basis, amounted to $1,104,840 of the $1.5 million available from federal funds in 1958-59. Through the 75 projects approved under these two grants, equipment was provided to 35 hospitals and rehabilitation centres, and support was given for the extension of services by 12 rehabilitation centres, ten hospital centres and clinics, 17 cerebral palsy training centres, six crippled children's services as well as by seven of the provincial programs. Other projects supported the full-time professional training of 47 rehabilitation personnel and additional bursaries for short courses, and also the operation of three university schools of physical, occupational and speech therapy.

Subsection 3. - Health Services in the Yukon and Northwest Territories

Health services in both Territories are operated under conditions considerably different from those in the provinces. Great, sparsely settled areas, climatic conditions, lack of local government together with direct federal administration constitute a basic set of conditions under which health services for both native and white populations outside the few settled areas come from government agencies or religious organizations.

The Yukon Territorial Government, the Northwest Territories Council, the Directorate of Indian and Northern Health Services of the Department of National Health and Welfare and the Departments of Northern Affairs and National Defence are all concerned with the provision of services.

Health services are supplied to Indians and Eskimos by Indian and Northern Health Services. Particular emphasis is given to tuberculosis and mass X-ray programs are carried out annually. The eastern arctic is served by the annual Eastern Arctic Patrol as well as by medical health officers. In the western arctic medical officers and nursing stations are located at strategic points and a travelling dentist is employed. Persons who cannot be cared for in local facilities are cared for in federal hospitals in the provinces.

In the Yukon Territory, services for the white population are administered through the Commissioner for the Yukon and include complete treatment for tuberculosis and poliomyelitis patients and hospital care for indigent residents. Public health services include communicable disease control, public health nursing, sanitary inspection and tuberculosis case-finding.

The Northwest Territories concluded an agreement in March 1960 with the federal government concerning hospital insurance, to become effective 1st April 1960. Health programs for the white population have included treatment for tuberculosis and venereal disease as well as dental care for children under 17 and hospital care for the mentally ill. Cancer diagnosis is provided through the Edmonton Clinic. Indigent residents are eligible for medical, dental and optical services as well as for general hospital care.

PART II. - PUBLIC WELFARE AND SOCIAL SECURITY

Responsibility for social welfare is shared by all levels of government. Costly income maintenance measures such as old age security and family allowances, or programs such as unemployment insurance and the National Employment Service where nation-wide co-ordination is required are administered federally. Substantial federal aid is given to the provinces in meeting the costs of social assistance. The Federal Government also provides services for special groups such as Indians, Eskimos and immigrants.

The Department of National Health and Welfare is the agency generally responsible for federal welfare matters; the Departments of Veterans Affairs, Citizenship and Immigration, and Northern Affairs and National Resources also operate important programs. The Unemployment Insurance Commission is responsible for the operation of unemployment insurance and the National Employment Service.

Administration of welfare services is primarily a responsibility of the province but the provision of services is often assumed by local authorities, generally with financial aid from the province.

SECTION I. - FEDERAL GOVERNMENT PROGRAMS

Subsection 1. - Family Allowances

The Family Allowances Act of 1944 is designed to assist in providing equal opportunity for all Canadian children. The allowances do not involve a 'means test' and are paid entirely from the federal Consolidated Revenue Fund. They do not constitute taxable income but there is a smaller income tax exemption for children eligible for allowances.

Allowances are payable in respect of every child under the age of 16 years who was born in Canada, or who has been a resident of the country for one year, or whose father or mother was domiciled in Canada for three years immediately prior to the birth of the child. Payment is made each month, normally to the mother, although any person who substantially maintains the child may be paid the allowance on his behalf. Allowances are paid at the monthly rate of $6 for each child under ten years and $8 for each child ten or over but under 16 years. The allowances are paid by cheque, except for some Eskimo and Indian children in remote areas for whom payment is made largely in kind because of lack of exchange facilities and the desirability for education in the use of nutritive foods.

If the allowances are not spent for the purposes outlined in the Act payment may be discontinued or made to some other person or agency on behalf of the child. Allowances are not payable for any child who fails to comply with provincial school regulations or on behalf of a girl who is married and under 16 years of age.

The program is administered by the Department of National Health and Welfare through regional offices located in each provincial capital. A welfare section in each regional office deals with welfare questions arising from administration of the allowances. Issuing of the cheques is the responsibility of the treasury division of each regional office which reports to the Chief Treasury Officer of the Department of Finance attached to the Department of National Health and Welfare. The Regional Director for the Yukon and Northwest Territories is located in Ottawa.

Through the Department of Citizenship and Immigration the Federal Government pays family assistance at the rate of $5 a month for each child under 16 years of age supported by an immigrant who has landed for permanent residence in Canada, or by a Canadian returning to Canada to reside permanently. This allowance, which is paid quarterly and for a maximum period of one year, is not payable to a child receiving family allowances.

1. -- Family Allowances Statistics, by Province, Years Ended Mar. 31, 1956-59

Province and Year	Families Receiving Allowance in March	Children for Whom Allowance Paid in March	Average Number of Children per Family in March	Average Allowance[1]		Net Total Allowances Paid during Fiscal Year
				Per Family	Per Child	
	No.	No.	No.	$	$	$
Newfoundland..........1956	58,223	175,474	3.01	18.07	5.99	12,414,789
1957	59,572	181,237	3.04	18.31	6.02	12,881,415
1958	60,961	187,035	3.07	20.40	6.65	14,131,153
1959	62,203	192,030	3.09	20.57	6.66	15,162,900
Prince Edward Island..1956	13,151	36,144	2.75	16.67	6.07	2,621,722
1957	13,067	36,173	2.77	16.86	6.09	2,640,585
1958	13,240	36,839	2.78	18.61	6.69	2,824,310
1959	13,443	37,426	2.78	18.72	6.72	2,994,334
Nova Scotia...........1956	99,071	244,551	2.47	14.97	6.07	17,596,684
1957	99,957	248,827	2.49	15.13	6.08	17,973,392
1958	101,509	253,713	2.50	16.71	6.68	19,400,493
1959	103,105	258,684	2.51	16.79	6.69	20,560,462
New Brunswick.........1956	77,079	214,966	2.79	16.88	6.05	15,451,544
1957	77,833	218,703	2.81	17.05	6.07	15,779,360
1958	79,237	224,047	2.83	18.89	6.68	17,074,970
1959	80,857	229,505	2.84	19.00	6.69	18,201,518
Quebec................1956	623,961	1,675,840	2.68	16.36	6.09	120,389,838
1957	642,573	1,729,386	2.69	16.39	6.09	124,368,344
1958	664,852	1,786,800	2.69	18.02	6.70	136,080,634
1959	686,872	1,848,138	2.69	18.01	6.69	146,278,435
Ontario...............1956	773,535	1,657,561	2.14	12.87	6.00	116,604,314
1957	800,279	1,734,813	2.17	13.05	6.02	122,539,123
1958	833,495	1,825,274	2.19	14.59	6.66	136,706,314
1959	870,582	1,922,653	2.21	14.69	6.65	150,186,253
Manitoba..............1956	122,018	272,916	2.24	13.46	6.02	19,418,713
1957	122,386	276,912	2.26	13.65	6.03	19,888,717
1958	124,257	283,863	2.28	15.22	6.66	21,520,778
1959	126,989	292,697	2.30	15.34	6.66	23,091,594
Saskatchewan..........1956	127,175	296,027	2.33	14.10	6.06	21,401,114
1957	126,271	298,085	2.36	14.31	6.06	21,644,971
1958	127,904	306,045	2.39	15.89	6.64	23,241,829
1959	130,210	313,926	2.41	16.03	6.65	24,789,278
Alberta...............1956	167,705	380,095	2.27	13.57	5.99	26,752,793
1957	172,533	395,234	2.29	13.76	6.00	27,953,311
1958	179,237	414,550	2.31	15.36	6.64	31,029,720
1959	187,561	437,883	2.33	15.51	6.64	34,122,637
British Columbia......1956	196,955	412,819	2.10	12.67	6.04	29,097,077
1957	207,626	440,749	2.12	12.86	6.06	31,029,472
1958	217,009	466,169	2.15	14.35	6.68	34,969,036
1959	225,492	488,891	2.17	14.49	6.68	38,409,308

1 Based on gross payment for March.

1. -- Family Allowances Statistics, by Province, Years Ended Mar. 31, 1956-59 (Cont'd)

Province and Year	Families Receiving Allowance in March	Children for Whom Allowance Paid in March	Average Number of Children per Family in March	Average Allowance[1]		Net Total Allowances Paid during Fiscal Year
				Per Family	Per Child	
	No.	No.	No.	$	$	$
Yukon and Northwest Territories.1956	4,745	11,043	2.33	14.04	6.03	786,437
1957	4,794	11,317	2.36	14.00	5.93	819,150
1958	5,033	12,045	2.39	15.87	6.63	907,321
1959	5,267	13,423	2.55	17.21	6.75	990,349
Canada................1956	2,263,618	5,377,436	2.37	14.35	6.04	382,535,026
1957	2,326,891	5,571,436	2.39	14.49	6.05	397,517,840
1958	2,406,734	5,796,380	2.41	16.08	6.68	437,886,560
1959	2,492,581	6,035,256	2.42	16.15	6.67	474,787,068

1 Based on gross payment for March.

Subsection 2. -- Old Age Security

The Old Age Security Act of 1952, as amended November 1957, provides a universal pension of $55 a month, payable by the Federal Government to all persons age 70 or over, subject to a residence qualification. To qualify for pension a person must have resided in Canada for ten years immediately preceding its commencement or, if absent during that period, must have been actually present in Canada prior to it for double any period of absence and must have resided in Canada at least one year immediately preceding commencement of pension. The pension is suspended when a pensioner leaves Canada but on his return may be resumed and, if absence has not exceeded six months, may be paid retroactively for as many as six months of absence in any calendar year.

Until January 1, 1959, the pension was financed on a pay-as-you-go method through a 2-p.c. sales tax, a 2-p.c. tax on corporation income and, subject to a limit of $60 a year, a 2-p.c. tax on personal income. Effective January 1, 1959, the tax on corporation income and from April 9, 1959, the sales tax, were raised to 3-p.c. The rate on taxable personal income was raised, as from July 1, 1959, to 2.5-p.c., with a maximum of $75 for 1959. Beginning with 1960, the rate on taxable personal income was raised to 3-p.c., with a maximum of $90 a year. These earmarked taxes are paid into the Old Age Security Fund. If they are insufficient to meet the pension payments, temporary loans or grants are made from the Consolidated Revenue Fund. The pension is paid from the Consolidated Revenue Fund and charged to the Old Age Security Fund. The program is administered by the Department of National Health and Welfare through regional offices located in each provincial capital.

Persons in receipt of old age assistance who reach age 70 are automatically transferred to old age security. Others make application to the regional office.

British Columbia, Alberta and Saskatchewan make supplementary payments to those recipients of old age security who qualify under a means and residence test. In British Columbia the allowance may not exceed $20 a month, in Alberta $15 a month, in Saskatchewan it is a minimum of $2.50 a month rising to a maximum of $10 a month. In Ontario, the provincial government shares to the extent of 80 p.c. in the first $20 a month of supplement paid by a municipality to a needy recipient of old age security. In Manitoba, the province may reimburse a municipality for 80 p.c. of the supplementary assistance paid to needy recipients of old age security. In some provinces and in Yukon Territory, recipients of the pension who are in special need may be eligible for relief.

2. -- Operationes of the Old Age Security Fund, Years Ended Mar. 31, 1955-59

Item	Year Ended Mar. 31--				
	1955	1956	1957	1958	1959
	$	$	$	$	$
Revenue...........	353,205,333	366,218,474	379,111,374	473,859,104	559,279,858
Individual income tax............	100,900,000	102,500,000	124,999,000	135,001,000	146,350,000
Corporation income tax.....	46,000,000	53,328,000	67,336,000	60,664,000	55,328,000[1]
Sales tax........	143,053,678	160,377,617	179,270,141	175,792,442	173,622,697
Grant from Consolidated Revenue Fund...	---	---	6,000,000	102,401,662	183,979,162
Loan from Consolidated Revenue Fund...	63,251,655[2]	50,012,857[2]	1,506,233[2]	---	---
Expenditure (Benefit Payments)....	353,205,333	366,218,474	379,111,374	473,859,104	559,279,858

1 The rate paid with respect of Corporation income was increased from two per cent to three per cent, effective January 1st, 1959.

2 Loans from Consolidated Revenue were written off by grants from the Consolidated Revenue Fund in following fiscal years.

3. -- Old Age Security Statistics, by Province, Years Ended Mar. 31, 1956-59

Province and Year		Pensioners in March	Pensions Paid during Fiscal Year (net)
		No.	$
Newfoundland	1956	15,973	7,599,405
	1957	16,248	7,738,205
	1958	16,557	9,490,737
	1959	16,782	11,012,906
Prince Edward Island	1956	6,884	3,313,980
	1957	6,993	3,371,370
	1958	7,100	4,139,668
	1959	7,153	4,809,942
Nova Scotia	1956	38,212	18,411,345
	1957	38,860	18,706,153
	1958	39,694	23,008,418
	1959	40,395	26,780,353
New Brunswick	1956	27,513	13,246,139
	1957	28,170	13,528,005
	1958	28,956	16,747,674
	1959	29,509	19,583,702
Quebec	1956	163,173	77,110,979
	1957	168,407	79,650,588
	1958	174,476	99,490,164
	1959	179,829	116,993,184
Ontario	1956	283,171	134,644,236
	1957	291,493	138,792,796
	1958	301,183	172,804,152
	1959	310,094	203,257,138
Manitoba	1956	46,396	21,953,425
	1957	47,908	22,842,472
	1958	50,079	28,562,399
	1959	52,066	34,029,850
Saskatchewan	1956	47,101	22,331,244
	1957	48,984	23,334,799
	1958	51,300	29,420,360
	1959	53,469	35,099,989
Alberta	1956	48,163	22,681,995
	1957	50,524	23,942,472
	1958	53,319	30,443,217
	1959	55,968	36,534,769
British Columbia	1956	94,611	44,657,286
	1957	99,320	46,923,834
	1958	104,297	59,408,009
	1959	108,396	70,769,169
Yukon and Northwest Territories	1956	556	268,440
	1957	579	280,680
	1958	599	344,305
	1959	623	408,856
Canada	1956	771,753	366,218,474
	1957	797,486	379,111,374
	1958	827,560	473,859,103
	1959	854,284	559,279,858

SECTION 2 -- FEDERAL-PROVINCIAL PROGRAMS

Subsection 1. -- Old Age Assistance

The Old Age Assistance Act of 1952, as amended November 1957, provides for federal reimbursement to the provinces for assistance to persons aged 65 or over who are in need and who have resided in Canada for at least ten years or who, if absent from Canada during this period, have been present in Canada prior to the commencement of the ten-year period for double any period of absence. On reaching age 70 a pensioner is transferred to old age security. The federal contribution may not exceed 50 p.c. of $55 a month or of the assistance paid, whichever is less. The province administers the program and, within the limits of the federal Act, may fix the amount of assistance payable, the maximum income allowed and other conditions of eligibility. All provinces and territories pay a maximum of $55 a month.

For an unmarried person, total income allowed, including assistance, may not exceed $960 a year. For a married couple it may not exceed $1,620 a year or, when the spouse is blind within the meaning of the Blind Persons Act, $1,980 a year. Assistance is not paid to a person receiving an allowance under the Blind Persons or War Veterans Allowance Acts.

British Columbia, Alberta and Yukon Territory make supplementary payments to recipients of old age assistance who qualify under a means and residence test. In British Columbia the allowance may not exceed $20 a month, in Alberta $15 a month, and in the Yukon $10 a month. In Ontario the provincial government shares to the extent of 80 p.c. in the first $20 a month of the supplement paid by a municipality to a needy recipient of old age assistance. In Manitoba, the province is empowered to reimburse a municipality for 80 p.c. of the supplementary assistance it pays to recipients of old age assistance. In some provinces and in the Yukon, recipients of old age assistance who are in special need may be eligible for relief.

4. -- Old Age Assistance Statistics, by Province, Years Ended Mar. 31, 1956-59

Province and Year		Recipients in Month of March	Average Amount of Monthly Assistance	P.C. of Recipients to Population Age 65 - 69	Federal Government Contribution during Year
		No.	$		$
Newfoundland	1956	4,848	29.42	52.13	877,213
	1957	4,893	38.08[1]	52.61	1,015,306
	1958	5,119	53.63[2]	57.52	1,298,770
	1959	5,378	53.20	61.11	1,715,386
Prince Edward Island	1956	600	27.69	18.18	99,660
	1957	580	28.04	17.58	98,143
	1958	659	45.55[2]	19.97	142,258
	1959	756	44.45	22.24	191,759
Nova Scotia	1956	5,081	33.73	25.92	1,046,927
	1957	4,950	33.95	25.26	1,020,529
	1958	5,219	50.15[2]	26.10	1,318,055
	1959	5,485	49.40	27.29	1,611,693
New Brunswick	1956	5,891	36.86	39.54	1,303,189
	1957	5,624	36.92	37.74	1,271,433
	1958	5,724	52.46[2]	37.17	1,559,905
	1959	5,795	51.62	37.63	1,829,266
Quebec	1956	32,227	37.51	31.17	7,357,373
	1957	31,031	37.47	30.01	7,107,138
	1958	32,318	52.45[2]	30.84	8,702,893
	1959	34,134	51.88	32.23	10,593,250
Ontario	1956	21,731	36.90	13.19	4,918,978
	1957	20,744	36.93	12.59	4,659,319
	1958	21,077	51.76[2]	12.56	5,650,281
	1959	22,381	48.96	13.28	6,707,318
Manitoba	1956	4,652	37.84	16.50	1,111,604
	1957	4,560	37.88	16.17	1,058,780
	1958	4,474	53.37[2]	15.48	1,297,115
	1959	4,836	51.98	17.27	1,572,890
Saskatchewan	1956	4,925	37.05	17.22	1,150,402
	1957	4,963	37.11	17.35	1,154,375
	1958	5,129	52.52[2]	17.45	1,435,188
	1959	5,537	51.35	19.50	1,763,549
Alberta	1956	5,521	36.16	18.28	1,240,452
	1957	5,400	36.14	17.88	1,211,188
	1958	5,715	51.33[2]	18.26	1,538,751
	1959	6,096	50.62	19.54	1,877,243
British Columbia	1956	7,441	37.68	14.53	1,788,308
	1957	7,029	37.67	13.73	1,665,347
	1958	6,906	52.91[2]	12.86	1,979,058
	1959	7,276	51.96	13.73	2,291,662
Yukon Territory	1956	20	40.00	10.00	3,080
	1957	31	40.00	15.50	6,640
	1958	41	46.00[3]	21.47	9,726
	1959	38	51.02	19.90	39,989

4. -- Old Age Assistance Statistics, by Province
Years Ended Mar. 31, 1956-59 (Cont'd)

Province and Year	Recipients in Month of March	Average Amount of Monthly Assistance	P.C. of Recipients to Population Age 65 - 69	Federal Government Contribution during Year
	No.	$		$
Northwest Territories 1956	86	37.93	43.00	21,000
1957	102	37.96	51.00	22,597
1958	103	53.99[2]	48.58	29,385
1959	124	55.00	58.49	13,280
Canada 1956	93,023	36.56	20.49	20,918,186
1957	89,907	37.03	19.81	20,290,795
1958	92,484	52.19	19.94	24,961,383
1959	97,836	50.97	20.91	30,207,284

1 During fiscal year maximum assistance raised from $30 to $40 per month.

2 During fiscal year maximum raised from $40 to $55 a month.

3 During fiscal year monthly maximum raised from $40 to $46. Raised to $55 in May 1958, retroactive to Nov. 1, 1957.

Subsection 2. -- Blindness Allowances

The Blind Persons Act of 1952, as amended November 1957, provides for federal reimbursement to the provinces for allowances to blind persons aged 18 or over who are in need and who have resided in Canada for at least ten years. The federal contribution may not exceed 75 p.c. of $55 a month or of the allowance paid, whichever is less. The province administers the program and, within the limits of the federal Act, may fix the amount of allowance payable and the maximum income allowed. All provinces pay a maximum of $55 a month.

To qualify for an allowance a person must meet the required definition of blindness and have resided in Canada for ten years immediately preceding commencement of allowance or, if absent from Canada during this period, must have been present in Canada prior to its commencement for a period equal to double any period of absence.

For an unmarried person, total income including the allowance may not exceed $1,200 a year; for a person with no spouse but with one or more dependent children, $1,680; for a married couple, $1,980. When the spouse is also blind, income of the couple may not exceed $2,100. Allowances are not payable to a person receiving assistance under the Old Age Assistance Act, an allowance under the War Veterans Allowance Act, a pension under the Old Age Security Act or a pension for blindness under the Pensions Act.

British Columbia, Alberta, Saskatchewan and Yukon Territory make supplementary payments to recipients of blindness allowances who qualify under income and residence tests. In British Columbia, a flat rate allowance of $20 a month is payable, in Alberta the supplement may not exceed $15 a month and in the Yukon $10 a month. In Saskatchewan a minimum of $2.50 a month is payable, rising to a maximum of $10 a month. In Ontario the government shares to the extent of 80 p.c. in the first $20 a month paid by a municipality to a needy recipient. In Manitoba, the province is empowered to reimburse a municipality for 80 p.c. of the supplementary assistance it pays to recipients of allowances for blind persons. In some provinces and in the Yukon, recipients in special need may also be eligible for relief.

5. -- Statistics of Allowances for the Blind, by Province, Years Ended Mar. 31, 1956-59

Province and Year		Recipients in Month of March	Average Amount of Monthly Allowance	P.C. of Recipients to Population Age 20 - 69	Federal Government Contribution during Year
		No.	$		$
Newfoundland	1956	353	39.65	0.178	126,038
	1957	370	39.47	0.186	132,559
	1958	376	54.45[1]	0.190	152,688
	1959	407	54.41	0.197	199,975
Prince Edward Island	1956	96	37.52	0.181	32,279
	1957	90	37.38	0.170	31,267
	1958	96	53.13[1]	0.198	37,568
	1959	87	53.48	0.174	43,338
Nova Scotia	1956	726	39.55	0.198	254,604
	1957	714	39.25	0.194	258,064
	1958	745	53.92[1]	0.204	312,969
	1959	787	53.40	0.214	376,544
New Brunswick	1956	717	39.50	0.250	258,432
	1957	719	39.53	0.251	258,340
	1958	715	53.94[1]	0.258	310,481
	1959	724	53.90	0.252	357,742
Quebec	1956	2,905	39.44	0.118	1,036,243
	1957	2,918	39.32	0.118	1,046,209
	1958	2,956	54.41[1]	0.117	1,264,975
	1959	3,056	54.06	0.116	1,500,856
Ontario	1956	1,719	39.35	0.056	609,974
	1957	1,713	39.09	0.056	613,014
	1958	1,720	53.73[1]	0.053	735,344
	1959	1,833	50.75	0.054	867,247
Manitoba	1956	411	39.60	0.085	145,547
	1957	402	39.60	0.083	147,725
	1958	392	54.33[1]	0.082	170,031
	1959	409	53.51	0.085	198,649
Saskatchewan	1956	389	38.84	0.079	135,219
	1957	399	38.80	0.081	141,797
	1958	412	53.32[1]	0.088	176,095
	1959	417	53.01	0.088	203,034
Alberta	1956	415	38.54	0.070	145,707
	1957	418	39.25	0.070	151,071
	1958	451	53.63[1]	0.071	188,604
	1959	464	53.22	0.070	223,721
British Columbia	1956	475	39.52	0.062	166,772
	1957	482	39.17	0.062	169,387
	1958	505	53.67[1]	0.059	213,809
	1959	530	53.61	0.060	248,774
Yukon Territory	1956	6	40.00	0.105	1,350
	1957	6	40.00	0.105	2,160
	1958	5	46.00[2]	0.068	2,300
	1959	5	55.00	0.069	2,506

5. -- Statistics of Allowances for the Blind, by Province, Years Ended Mar. 31, 1956-59 (Cont'd)

Province and Year	Recipients in Month of March	Average Amount of Monthly Allowance	P.C. of Recipients to Population Age 20 - 69	Federal Government Contribution during Year
	No.	$		$
Northwest Territories 1956	18	40.00	0.212	6,330
1957	25	38.60	0.294	7,447
1958	27	51.85[1]	0.260	10,861
1959	28	51.96	0.262	12,746
Canada 1956	8,230	39.36	0.093	2,918,495
1957	8,256	39.24	0.094	2,959,040
1958	8,400	54.02	0.092	3,575,724
1959	8,747	53.15	0.092	4,235,131

1 During fiscal year maximum raised from $40 to $55 a month.

2 During fiscal year maximum raised from $40 to $46 a month. Raised to $55 a month in May 1958, retroactive to Nov. 1, 1957.

Subsection 3. -- Disability Allowances

The Disabled Persons Act of 1954, as amended November 1957, provides for federal reimbursement to the provinces for allowances paid to permanently and totally disabled persons aged 18 or over who are in need and who have resided in Canada for at least ten years immediately preceding commencement of allowance or, if absent from Canada during this period, have been present in Canada prior to its commencement for a period equal to double any period of absence. To qualify for an allowance a person must meet the definition of permanent and total disability set out in the Regulations to the Act. The federal contribution may not exceed 50 p.c. of $55 a month or of the allowance paid, whichever is less. All provinces and territories pay a maximum of $55 a month. The province administers the program and, within the limits of the federal Act, may fix the amount of allowance payable, the maximum income allowed and other conditions of eligibility.

For an unmarried person, total income including the allowance may not exceed $960 a year. For a married couple the limit is $1,620 a year except that if the spouse is blind within the meaning of the Blind Persons Act, income of the couple may not exceed $1,980 a year. Allowances are not paid to a person receiving an allowance under the Blind Persons Act or the War Veterans Allowance Act, assistance under the Old Age Assistance Act, a pension under the Old Age Security Act, or the mothers' allowance.

The definition of permanent and total disability employed under the Act required that a person must be suffering from a major physiological, anatomical or psychological impairment, verified by objective medical findings. The impairment must be one that is likely to continue indefinitely without substantial improvement and that will severely limit activities of normal living.

The allowance is not payable to a patient in a mental institution or tuberculosis sanatorium. A recipient who is resident in a nursing home, an infirmary, a home for the aged, an institution for the care of incurables or a private, charitable or public institution is eligible for the allowance only if the major part of the cost of his accommodation is being paid by himself or any other individual. When a recipient is required to enter a public or private hospital the allowance may be paid for no more than two months of hospitalization in a calendar year, excluding months of admission and release, but

for the period that a recipient is in hospital for therapeutic treatment for his disability or rehabilitation, as approved by the provincial authority, the allowance may continue to be paid. The provincial authority must suspend the payment of the allowance when it its opinion the recipient unreasonably neglects or refuses to comply with or to avail himself of training rehabilitation or treatment facilities provided by or available in the province.

In the fourth year of the program, disabilities in the two medical classes, mental, psychoneurotic and personality disorders, and diseases of the nervous system and sense organs were again found to be most prevalent among those persons becoming eligible for an allowance. These classes alone accounted for 47.5 p.c. of the new cases, an increase over the 41 p.c. in the fiscal year 1957-58. Other classes, however, such as diseases of the bones and organs of movement, and diseases of the circulatory system, continued to decline. Mental deficiency, the most frequently occurring disability, rose from one sixth to over one fifth of all cases granted an allowance.

British Columbia pays a flat rate supplement of $20 a month to recipients of disability allowances who qualify under a residence test. In Ontario, the government shares to the extent of 80 p.c. in the first $20 a month paid by a municipality to a needy recipient. In Manitoba, the province is empowered to reimburse a municipality for 80 p.c. of the supplementary assistance it pays to needy recipients of disability allowances. In some provinces and in Yukon Territory recipients in special need may also be eligible for relief.

6. -- Statistics of Allowances for Disabled Persons, by Province, Years Ended Mar. 31, 1956-59

Province and Year		Recipients in Month of March	Average Amount of Monthly Allowance	P.C. of Recipients to Population Age 20 - 69	Federal Government Contribution during Year
		No.	$		$
Newfoundland	1956	606	39.08	0.305	119,326
	1957	720	39.44	0.363	163,167
	1958	822	54.78[1]	0.415	205,845
	1959	980	54.69	0.475	302,224
Prince Edward Island	1956	292	32.84	0.552	56,703[2]
	1957	345	33.94	0.652	65,690
	1958	460	52.12[1]	0.950	113,222
	1959	596	51.28	1.194	169,016
Nova Scotia	1956	1,172	34.86	0.319	254,326
	1957	1,465	35.69	0.399	290,339
	1958	1,790	52.56[1]	0.491	456,948
	1959	2,184	52.65	0.593	662,727
New Brunswick	1956	947	39.13	0.330	218,644
	1957	1,262	39.43	0.440	281,859
	1958	1,474	54.62[1]	0.531	404,650
	1959	1,734	54.24	0.603	552,338
Quebec	1956	12,128	38.81	0.491	2,561,941[2]
	1957	15,856	38.97	0.642	3,593,395
	1958	22,929	53.75[1]	0.905	6,048,901
	1959	25,352	53.94	0.961	8,362,518
Ontario	1956	7,501	39.24	0.244	1,712,426
	1957	8,065	39.27	0.262	1,853,110
	1958	9,412	54.24[1]	0.289	2,523,956
	1959	11,469	53.88	0.339	3,485,924
Manitoba	1956	738	39.00	0.153	172,350
	1957	819	39.23	0.169	192,867
	1958	1,028	54.36[1]	0.215	273,555
	1959	1,230	54.14	0.255	381,004
Saskatchewan	1956	788	38.20	0.160	162,884
	1957	988	38.68	0.200	221,966
	1958	1,146	54.20[1]	0.244	317,011
	1959	1,248	54.15	0.264	405,443
Alberta	1956	1,150	38.01	0.193	290,947[2]
	1957	1,245	38.17	0.209	276,593
	1958	1,492	53.59[1]	0.235	396,826
	1959	1,648	53.09	0.248	515,932
British Columbia	1956	705	39.00	0.091	115,521[2]
	1957	1,067	39.01	0.138	227,926
	1958	1,281	54.18[1]	0.150	349,100
	1959	1,585	53.98	0.179	490,156
Yukon Territory	1956				
	1957				
	1958			0.028	192
	1959				

6. -- Statistics of Allowances for Disabled Persons, by Province, Years Ended Mar. 31, 1956-59 (Cont'd)

Province and Year	Recipients in Month of March	Average Amount of Monthly Allowance	P.C. of Recipients to Population Age 20 - 69	Federal Government Contribution during Year
	No.	$		$
Northwest Territories 1956				
1957	3	40.00	0.035	440
1958	6	55.00	0.058	1,651
1959	12	54.58	0.112	2,893
Canada .... 1956[3]	26,027	38.66	0.296	5,665,068
1957[3]	31,835	38.84	0.361	7,167,352
1958[3]	41,840	53.88	0.459	11,091,664
1959	48,040	53.84	0.508	15,330,368

1 During fiscal year maximum payment increased from $40 to $55 a month.

2 Includes certain amounts retroactive to Jan. 1, 1955, when program became effective.

3 Excluding Yukon Territory.

Subsection 4. -- Unemployment Assistance

Under the Unemployment Assistance Act of 1956, the Federal Government may share with a province and its municipalities 50 p.c. of the cost of financial assistance to unemployed persons. A 1957 amendment deleted a provision under which federal reimbursement is made only in respect of recipients in excess of 0.45 p.c. of the provincial population. No distinction is made in the legislation between the employable and the unemployable.

Reimbursement is made to the province for payments within the existing provincial framework of general assistance. The scale and conditions of relief payments to recipients continue to be determined by the provinces and municipalities except that the province agrees not to make length of residence a condition for the receipt of assistance when an applicant comes from another province which has signed a similar agreement.

The Act excludes federal reimbursement for payments for persons receiving mothers' allowances. While it also generally excludes inmates of public and charitable institutions, it provides for federal sharing of provincial and municipal payments for those in certain types of homes for special care. Those receiving various types of social security payments under other programs are also excluded but the Federal Government shares with the provinces any additional relief payments, other than cost-of-living bonus or across-the-board pension supplements, made to such persons who are unemployed and in need. Health care and administration costs are also excluded from Federal Government reimbursement.

Agreements for the payment of federal assistance, effective July 1, 1955, were made with five provinces--Newfoundland, Prince Edward Island, Manitoba, Saskatchewan and British Columbia. New Brunswick and Ontario entered the scheme, effective Jan. 1, 1956, and Dec. 1, 1956, respectively; and Nova Scotia and Alberta, effective from Jan. 1, 1958. At the end of 1958 the Northwest Territories signed an agreement effective Jan. 1 of that year and in 1959 Quebec and Yukon Territory entered into agreements effective July 1, 1958 and Jan. 1, 1959, respectively. All parts of Canada were thus participating in the programme in 1959, though at the end of the year reimbursement claims covering the period of the agreement had not been received from Quebec and the Yukon.

7. -- Unemployment Assistance, by Province, Years Ended Mar. 31, 1956-59

Province and Year		Federal Share of Unemployment Assistance Costs	Recipients in March
		$	No.
Newfoundland	1956[1]	1,174,735	38,641
	1957	1,562,058	39,489
	1958	1,787,626	45,799
	1959	3,040,767	58,264
Prince Edward Island	1956[1]	55,033	1,596
	1957	54,036	1,532
	1958	73,010	1,724
	1959	67,726	1,418
Nova Scotia	1958[2]	76,179	5,083
	1959	298,458	9,209
New Brunswick	1956[3]	18,854	3,843
	1957	32,887	3,797
	1958	94,217	5,800
	1959	180,614	7,589
Ontario	1957[4]	640,103	37,512
	1958	3,617,332	61,623
	1959	9,325,564	79,385
Manitoba	1956[1]	492,692	10,905
	1957	668,652	9,836
	1958	549,842[5]	--
	1959	1,604,219	16,065
Saskatchewan	1956[1]	369,519	10,464
	1957	512,678	10,123
	1958	813,080	12,873
	1959	1,420,618	15,507
Alberta	1958[2]	--	--
	1959	1,858,633	15,899
British Columbia	1956[1]	1,721,339	20,785
	1957	2,299,894	21,289
	1958	2,828,568	24,341
	1959	6,136,935	39,388
Northwest Territories	1959	5,921	157
Totals	1956	3,832,173	86,234
	1957	5,770,310	123,578
	1958	9,839,854	157,243
	1959	23,939,455	242,881

1 Agreement effective from July 1, 1955.

2 Agreement effective from Jan. 1, 1958.

3 Agreement effective from Jan. 1, 1956.

4 Agreement effective from Dec. 1, 1956.

5. Eight months only.

SECTION 3. -- PROVINCIAL PROGRAMS

Subsection 1. -- Mothers' Allowances

All provinces make statutory provision for allowances to needy mothers who are deprived of the breadwinner and are unable to maintain their dependent children without assistance. Mothers' allowances programs, whether set out in separate Acts or included in general assistance legislation are, in most provinces, administered as separate programs. In British Columbia, since September 1, 1958, aid is provided to needy mothers as to other needy persons under the social assistance program.

The following remarks do not apply to British Columbia, although Table 9 includes data for British Columbia for the year ended Mar. 31, 1958.

Subject to conditions of eligibility which vary from province to province, mothers' allowances are payable from provincial funds to applicants who are widowed or whose husbands are mentally incapacitated and, except in Alberta, to those whose husbands are physically disabled and unable to support their families. They are also payable to deserted wives who meet specified conditions; in several provinces to mothers who have been granted a divorce or legal separation; in some to unmarried mothers; and in Ontario and Quebec to certain Indian mothers. Foster mothers may be eligible under particular circumstances in most provinces.

The age limit for children varies from 15 years in one province to 18 in another with provision made in most provinces to extend payment for a specified period if the child is attending school or if he is physically or mentally handicapped.

In all provinces applicants must satisfy conditions of need and residence but the amount of outside income and resources allowed and the length of residence required prior to application vary, the most common period being one year, although in one province it is five years. Three provinces have citizenship requirements.

In each province the relevant Act is administered by public welfare authorities. In some provinces a Mothers' Allowances Board or Commission makes the final decision regarding eligibility and the amount of allowances granted, or acts in an advisory capacity. Rates of benefit as of July 1959 are given in Table 8 and the number of families and children assisted and the amounts of benefits paid as at Mar. 31, 1957-59, in Table 9.

8. -- Maximum Monthly Rates Under Provincial Mothers' Allowances Legislation, July 1959

ovince	Mother and One Child	Each Additional Child	Disabled Father at Home	Family Maximum	Supplementary
1	Food: \$33 or \$37 depending on age of child Clothing: to \$2 for child under age 6, to \$3 for child age 6 and under age 16, to \$5 for person age 16 or over. Rent: up to \$20 monthly in rural and to \$30 monthly in urban areas. Fuel: up to \$10.	\$8 for each child under age 16. \$12 for each child age 16 or over.	\$20	None set	In special circumstances up to \$30 a month additional if necessary for proper support of family
I.	\$45	\$5	No additional allowance granted	\$75	None granted
	No set maximum; rates are based on average family income for community in which family lives		Included in budget	\$90	None granted
	\$35	\$10	No additional allowance granted	\$80	Director may grant an additional \$10 for rent if circumstances require it but only if allowance paid is below maximum.

8. -- Maximum Monthly Rates Under Provincial Mothers' Allowances Legislation, July 1959 (Cont'd)

vince	Mother and One Child	Each Additional Child	Disabled Father at Home	Family Maximum	Supplementary
	$50	$10	$10	None set (minimum granted $5).	A supplementary allowance of $5 may be paid to a beneficiary incapable of working. Where need exists a special monthly allowance may be paid under the Quebec Public Charities Act through the municipality or a social agency. The cost is met in large part by the province, with some contribution by the municipality.
	$120 for mother or father and one child. $30 for one child living with foster mother.	$16 for 2nd child $14 for 3rd child $12 for 4th child $10 for 5th child $8 for 6th child $25 for 2nd foster child $15 for each additional foster child	Included in budget	$180	An increase in food allowance may be granted on medical recommendation. A fuel allowance of up to $24 a month may be granted from Sept. 1 to Mar. 31. An increase of 20 p.c. in fuel allowance may be granted under special circumstances.
	Food, clothing and utilities; $47-$59 depending on age of child. Shelter: rent to $55, or taxes, insurance and minor repairs up $20 plus principal and interest on mortgage or agreement for sale and necessar[illegible] irs.	$14 for child up to 3 years $16 for child 4-6 years $21 for child 7-11 years $26 for child 12-18 years (Subject to deductions for fourth and each additional child)	$25	None set	$10 monthly if family has no income. In case of extraordinary need up to $180 a year may be granted; if housekeeper service is required this amount may be exceeded. Fuel allowance granted for eight months.

8. -- Maximum Monthly Rates Under Provincial Mothers' Allowances Legislation, July 1959 (Concluded)

...vince	Mother and One Child	Each Additional Child	Disabled Father at Home	Family Maximum	Supplementary
...	$60 $35 for one child living with a guardian.	$10 $20 for each child living with guardian.	$20 Also if confined to a nursing home or sanatorium.	$150 $170 if disabled father at home, in nursing home or sanatorium.	The local municipality may grant supplementary aid under the Social Assistance program. In unorganized territories the province assumes full cost.
...	$70	$20 for 2nd and 3rd child $15 for 4th to 6th child $10 for 7th to 9th child.	Not applicable	$185	Municipalities of residence may grant additional aid, 80 p.c. of the cost of which is reimbursed by the province; in unorganized territories the province assumed full cost.

...Allowances to needy mothers are paid under the Social Assistance Act.

9. -- Mothers' Allowances, by Provinces, as at March 31, 1958-59

Province and Year		Families Assisted	Children Assisted	Benefits Paid
		No.	No.	$
Newfoundland	1958[1]	-	-	-
	1959	3,770	10,250 [2]	2,859,072 [2]
Prince Edward Island	1958	266	712	88,740
	1959	276	729	128,982
Nova Scotia	1958	2,131	5,966	1,576,585
	1959	2,196	5,483	1,887,882
New Brunswick	1958	2,213	6,360	1,336,043
	1959	2,235	6,495	1,365,075
Quebec	1958	21,766	63,121	14,611,986
	1959	22,403	64,969	18,991,476
Ontario	1958	8,580	20,247	8,947,401
	1959	9,433	22,632	11,033,373
Manitoba	1958	1,121	2,680	1,091,629
	1959	823	2,263	1,324,993
Saskatchewan	1958	2,279	5,792	1,573,190
	1959	2,222	5,491	2,030,322
Alberta	1958	1,879	4,234	1,512,651
	1959	2,093	4,768	1,857,031
British Columbia	1958	243	584	143,000 [3]
	1959[4]	-	-	-
Canada	1958[5]	40,478	109,696	30,881,225
	1959	45,451	123,080	41,478,206

1 Figures not available.

2 Approximate.

3 Not including an estimated $144,000 paid as supplementation from social allowance funds.

4 Caseload transferred to social assistance and no separate figures available.

5 Exclusive of Newfoundland (see p.).

Subsection 2. -- Provincial Welfare Services

General assistance or relief, and the various welfare services associated with this form of aid, as well as the care of the aged, and the protection and care of neglected and dependent children are governed by provincial welfare legislation. Administrative and financial responsibility is shared by the province and its municipalities to a varying extent.

Provincial administration of welfare as of other provincial assistance is carried out through the department of public welfare or of health and welfare in each province. Several provincial welfare departments have established regional offices for administrative purposes and to provide consultative services to the municipalities.

Significant changes have taken place in provincial programs in the past few years. New or revised legislation or new procedures in a number of provinces have laid the basis for improved standards of service and administration; and reappraisal of services is still going forward.

The new developments are particularly notable in the field of general assistance or residual aid. Changes in these programs have been accompanied in several provinces by redistribution of costs between the province and the municipalities, and progress has been made in setting up minimum standards of administration and encouraging uniform rates of assistance throughout the province. The financial contribution of the federal Government to the provinces for unemployment assistance has doubtless been an important contributing factor in the realignment of provincial-municipal responsibilities.

All provinces are giving some consideration to the need for integrated planning on behalf of their older citizens. A number have increased their capital or maintenance grants to municipalities and to voluntary groups for homes for the aged and are assisting, also, in the construction of low-rental housing projects.

The main efforts in child welfare have been directed towards improvement of standards and greater flexibility of services, in particular, increasing emphasis on preventive casework services for children in their own homes, on the development of specialized children's institutions and on efforts to find adoption homes for all children in need of them.

An impressive number of voluntary agencies also contribute to community welfare including the welfare of families and children and of groups with special needs, such as the aged, recent immigrants, youth groups, and released prisoners. Family welfare agencies or combined family and child welfare agencies in urban centres, for example, offer casework services to families in need of counselling on problems such as marital relations, parent-child relations and family budgetting. Special efforts are being made, also, by a variety of agencies, to develop counselling and recreational services for older or retired people. Welfare councils and community planning councils contribute to the planning and co-ordination of local welfare services, with the co-operation of voluntary and public agencies alike.

The voluntary agencies include, also, child and youth organizations with recreational and character-building programs, which offer group participation in physical education, camping, the development of special skills, and other opportunities for healthful activity.

Local voluntary agencies and institutions are incorporated in most cases under provincial law. They may receive public grants, depending on the nature and standard of the services they render, although, with the exception of the semi-public children's aid societies, their main support is from united funds or community chests, or, if they operate under the auspices of religious or other organizations, from the organization that sponsors them.

Welfare services, public and private, are hampered by the continued shortage of qualified social workers. Short university courses in social work, periodic study institutes, and a more formal approach than in the past to in-service training are being developed to improve staff qualifications. A number of provincial departments are granting educational leave with pay or bursaries to enable selected staff to attend schools of social work.

General Assistance. - All provinces make legislative provision for general assistance on a means test basis to needy persons and their dependents; who cannot qualify for other forms of aid, and some provinces include those whose benefits under other programs are not adequate. This assistance, with some exceptions, is administered by the municipality with substantial financial support from the Province. In most provinces assistance is given for food, clothing, shelter and utilities, but it may also cover other aid such as, incapacitation or rehabilitative allowances, post-sanatorium allowances, maintenance costs of boarding or nursing home care, counselling, and home-making services.

The provincial departments of public welfare usually have regulatory powers over municipal administration of general assistance. Several provinces recommend rates of assistance as a guide to municipalities, and some specify rates at which payments must be paid if a municipality is to qualify for provincial reimbursement. Specified standards of administration may also be a requirement. The province may take responsibility for aid in unorganized areas and for the cost of aid to certain categories of persons, such as transients. With the introduction of reimbursement plans designed to equalize municipal responsibility, British Columbia and Saskatchewan have abolished municipal residence requirements. In other provinces the residence of the applicant, as defined by statute determines the financially responsible authority.

Length of residence is calculated variously, but in general, it is one year without social assistance. Under the terms of agreement under the Unemployment Assistance Act all provinces have agreed not to make residence a condition of assistance for applicants who come from another province. Persons without residence in the province may be given aid by the province or by the municipality, with or without a chargeback being made to the municipality of residence, or, depending on individual circumstances and the policy of the province, they may be returned to their place of residence.

Under the federal Unemployment Assistance Act all provinces are reimbursed for 50 per cent of financial assistance payments on behalf of needy unemployed, whether employable or unemployable, including those in homes for special care, as defined in the Act.

Various financial arrangements are in effect for sharing the costs of general assistance between the province and the municipality.

In Newfoundland, general assistance is the responsibility of the Province, and is administered by the Department of Public Welfare. In Prince Edward Island, the Department of Welfare and Labour provides direct social assistance in rural areas and assumes 75 per cent of the cost of assistance granted by the City of Charlottetown and the incorporated towns and villages. The Department also operates a province-wide program of financial aid to families where the breadwinner is suffering from tuberculosis and is unable to support the family. In Nova Scotia, social assistance is administered by the municipality, which receives reimbursement from the Department of Public Welfare for two-thirds of the cost of assistance given and one-half of the costs of administration. In New Brunswick, relief to needy persons is a local responsibility, and may be discharged through the provision of institutional aid, although outdoor relief is provided by an increasing number of municipalities.

In Quebec, assistance to indigent is frequently given in the form of institutional care but may also be provided through some municipal departments and private agencies. Costs are shared by the provincial Department of Social Welfare, the municipality and, where applicable, by the institution. Cities and towns bear 24 per cent of the cost, rural municipalities 15 per cent, the institution 33 1/3 per cent, and the Province the remainder. In Ontario, the Department of Public Welfare reimburses municipalities, up to a prescribed maximum, for 80 per cent of their expenditures on aid to needy persons and on incapacitation allowances for single needy handicapped residents.

The Social Allowance Act of Manitoba, passed in 1959, transferred from the municipalities to the Province responsibility for administering and financing aid to mentally or physically incapacitated persons whose disability is likely to last more than 90 days, and to persons unable to work because of their age. Aid to other needy persons, termed "indigent relief", remains under the municipalities. The Department of Health and Public Welfare continues to reimburse the municipalities to the extent of 40 per cent of the costs, or at a higher rate according to formula if costs exceed a specified amount. In Saskatchewan, through the Department of Social Welfare and Rehabilitation, the province bears approximately 93 per cent of the cost of assistance to needy persons granted by the municipalities. In accordance with the formula, the municipalities are assessed annually on a per capita basis for about 7 per cent of the total overall cost of social aid, and the Province reimburses each municipality 100 per cent of actual expenditures. In Alberta, the Province reimburses the municipalities for 80 per cent of the value of the assistance given. The Department of Public Welfare maintains two hostels and one welfare centre to care for unemployable single homeless men without municipal domicile.

The Province of British Columbia, through the Department of Social Welfare, reimburses the municipalities on a pooled basis for 90 per cent of the total cost of social assistance to needy persons. Also, the Province shares equally with the municipalities expenditures on salaries of social workers; a municipality with less than 15,000 population may arrange to have the Department undertake social work within the municipality and reimburse the Department on the basis of 30 cents per capita per year.

Care of the Aged. - Homes for the aged under provincial, municipal or voluntary auspices are provided for the aged and infirm in all provinces. Voluntary homes generally are provincially inspected in accordance with prescribed standards and in some provinces must be licensed. Most provinces contribute to the maintenance of elderly persons in homes for the aged either through general assistance or through statutes which relate particularly to these homes. Also as indicated above, 50 per cent of the payments on behalf of assistance cases in homes for the aged and infirm (homes for special care) are met by the federal Government.

Several provinces make capital grants towards the construction of homes, and in four provinces capital grants are also available to municipalities, voluntary organizations, or limited-dividend companies for the construction of low-rental housing.

Newfoundland maintains a Home for the Aged and Infirm at St. John's and also pays, in whole or in part, the cost of maintaining needy old people in homes for the aged and boarding homes. In 1955, a grant of 20 per cent of costs, to be paid over a ten year period, was made to a religious organization for the construction of a home, and provision is made for grants to similar projects under other auspices. The aged and infirm in Prince Edward Island are cared for in Falconwood Mental Hospital and in two provincial infirmaries.

In Nova Scotia the aged are cared for in municipal or county homes, in homes operated by religious or private organizations and in private boarding homes. The Province reimburses the municipalities for two-thirds of their expenditures for the maintenance of needy persons in municipal homes, subject to compliance with specified standards of care and accommodation. Homes for the aged receiving aid from the provincial Government are subject to provincial inspection. Homes for the aged in New Brunswick are operated under municipal, religious, fraternal and private auspices, and receive no direct financial support from the Province. Voluntary and proprietary homes are now subject to provincial licensing and inspection and must meet standards contained in regulations under the Health Act.

Institutional care for indigent old people in Quebec is provided through charitable institutions under the Public Charities Act. The Homes for the Aged Act authorizes the Province to erect and maintain homes for the aged and housing projects, or to make grants to voluntary organizations for this purpose. Standards in homes are governed by regulations under the Public Health Act.

Under the Ontario Homes for the Aged Act, municipalities must provide institutional or boarding home care for the aged. The Province contributes one-half of the cost of constructing approved homes and 70 per cent of their net operating and maintenance costs. It also pays up to 70 per cent of the costs of maintenance in approved boarding homes. Homes for the aged under voluntary auspices are approved, inspected and assisted under the Charitable Institutions Act, which provides for grants in aid of construction equalling 50 per cent of costs up to $2,500 per bed and maintenance grants of 75 per cent of the amount spend by the organization up to $3.40 per day for the maintenance of each resident. The Elderly Persons Housing Aid Act provides for grants to limited-dividend housing corporations building low-rental housing for elderly persons.

Institutions and boarding homes for the aged and infirm in Manitoba are supervised and licensed by the Department of Health and Public Welfare under public health legislation. Under the Elderly Persons Housing Act, the Province makes construction grants to municipalities and charitable organizations, equalling one-third of the costs of constructing or acquiring and renovating housing accommodation and homes for the aged. Grants may not exceed $1,400 and $1,667 for one and two persons housing units, respectively; $1,200 per bed for new homes for the aged; and $700 per bed for homes that have been renovated. Under the Social Allowances Act, 1959, the entire cost of assistance to those who, because of age or incapacity, require care by another or in a home for the aged for more than ninety days is borne by the Province.

Aged and infirm persons in Saskatchewan are cared for in four provincial nursing homes and in voluntary homes for the aged. The latter are inspected and licensed under the Housing Act. This Act also empowers the Province and municipalities to subscribe to the stock of limited-dividends housing companies building low-rental accommodation for older persons; the Province may also make loans to municipalities to assist them in subscribing. Capital grants amounting to 20 per cent of construction costs and maintenance grants equalling $40 per bed per year may be made to municipalities, church or charitable organizations sponsoring approved homes or housing projects. Costs of maintaining needy persons in homes for the aged are shared by the Province and the municipalities under the Social Assistance Act.

Under what are termed "master agreements" the Province of Alberta bears the cost of constructing and equipping homes for the aged and housing units on municipal land. Projects are operated by provincially incorporated foundations which include municipal councilmen in their membership; net costs of operation are borne by the municipalities. The Province also meets up to 80 per cent of the cost incurred by municipalities for the maintenance of elderly persons in housing projects and municipal or private homes. Private homes are municipally licensed.

British Columbia operates The Provincial Home for Elderly Homeless Men, The Provincial Infirmary for the chronically ill and, for senile and psychotic patients, three provincial homes for the aged. It also licenses and supervises homes for the aged and boarding homes and, where necessary, shares with the municipalities on a 90-10 basis the cost of maintaining needy residents. Under the Elderly Persons Housing Aid Act the Province makes grants amounting to one-third of construction costs to municipalities and non-profit corporations, including religious and service organizations, engaged in building homes or low-rental housing units for elderly citizens.

Child Care and Protection. - Child welfare services, which include child protection and care, services for unmarried parents, and adoption services are provided in all provinces under provincial legislation.

All provinces have some central authority, usually a division of child welfare within the department of welfare, responsible for direction of the child welfare program. Except in Quebec, where the Province does not administer services directly, the program may be administered by the provincial authority itself or the responsibility may be delegated under provincial child welfare Acts to local children's aid societies, that is, to voluntary agencies with boards of directors, operating under charter, under the general supervision of provincial departments. In Quebec, the child welfare services are administered by recognized voluntary agencies and institutions, religious and secular, including diocesan welfare agencies. In Newfoundland, Prince Edward Island, and Saskatchewan, they are administered by the Province and to a large extent, also, in Alberta, where, however, there is some delegation of authority to the municipality in the major cities. In Ontario and New Brunswick a network of local children's aid societies, operating under statutory authority are responsible for the services. In Nova Scotia, Manitoba and British Columbia, services are administered by local children's aid societies in the heavily populated areas, and by the Province in the remaining areas.

Children's aid societies and the recognized agencies in Quebec receive substantial provincial grants and sometimes municipal grants and in many areas, also, support from private subscriptions or from community chests or united funds. Maintenance costs for children in care of a voluntary or public agency may be borne in part by the municipality of residence with a substantial share contributed also by the Province or, as in Alberta, Manitoba, Prince Edward Island, and Newfoundland, these costs may be borne entirely by the Province.

The child welfare agencies, whether provincial offices or authorized private agencies, have the authority to investigate cases of alleged neglect and, if necessary, to apprehend a child and to bring the case before a judge upon whom rests the responsibility of deciding whether in fact the child is neglected. When neglect is proved, the court may direct that the child be returned to his parent or parents, under supervision, or be made a ward of the province or a children's aid society or, in Quebec, be placed under the authority of a suitable person or agency.

The appropriate agency is then responsible for making arrangements to meet the needs of the child in so far as community resources permit. The services may involve case work with families in their own homes, or care may be provided in foster boarding homes, in adoption homes, or, for children who need this form of care, in selected institutions. Children placed for adoption may be wards or they may be placed on the written consent of the parent. Special efforts, which are meeting with considerable success, are being made to find suitable homes for children found difficult to place for adoption because of age, disability, or ethnic differences. Adoptions, including those arranged privately, number about 10,000 annually.

Child welfare agencies make use of the small selective institution for placement of children who are forced to be away from their own homes for a short period or who may need preparation for placement in foster homes, and also for teenage children who may find it easier to fit into a group setting than into a foster home. A growing number of institutions are meeting this demand for special care by a reduction in their size or reorganization into small units, and by the introduction of training courses for staff and other measures for the improvement of standards. The development of small, highly specialized institutions, which function as treatment centres for emotionally disturbed children, has been of particular significance in recent years.

Institutions for children are governed by provincial child welfare legislation or by special statutes dealing with welfare institutions, and by provincial or municipal public health regulations. The institutions are generally subject to inspection and in some provinces to licensing, and are usually required to make reports to the province on the movement of children under their care. Sources of income may include private subscription, provincial grants, and maintenance payments on behalf of children in care, payable by the parents, the placing agency, or the responsible municipal or provincial department.

Services to unmarried parents include casework services to the mother, and possibly to the father, legal assistance in obtaining support for the child from the father, and foster home care or adoption services for the child. If necessary, support for unmarried mothers may be obtained under general assistance programs. In many centres, homes for unmarried mothers are operated under private or religious auspices.

Day nurseries for the children of working mothers have been established in only the larger centres outside of Ontario; these are under voluntary auspices and in four provinces subject to licensing. In Ontario, where municipal day nurseries have been established in most of the industrial centres, a Day Nurseries Act sets out standards for operation and licensing to be met by all agencies offering day care services. It also provides for reimbursement of one-half the operating and maintenance costs of municipal day nurseries.

PART III. -- NATIONAL VOLUNTARY HEALTH AND WELFARE ACTIVITIES

A number of national voluntary agencies carry on important work in the provision of health and welfare services, planning and education. These agencies, some of which are described below, supplement the services of the federal and provincial authorities in many fields and play a leading role in stimulating public awareness of health and welfare needs and in promoting action to meet them.

The Canadian Welfare Council. -- The Council, established in 1920, is a national voluntary association of organizations and individual citizens whose aim is to further the advancement of social welfare in Canada. Member organizations include community funds and councils, other private social agencies, various federal, provincial and municipal departments, and citizen groups and individuals active in the fields of health, welfare and recreation. It furnishes authoritative information, technical consultation and field service in the main areas of social welfare and provides a means of co-operative planning and action by public and private agencies.

The policies and programs of the Council are determined by its members under the leadership of a nationally representative board of governors. Aided by professional staff, the members work together through Divisions of Family and Child Welfare, Public Welfare, Corrections, and Community Funds and Councils, and through special committees on such subjects as welfare of immigrants and the aging. Departments of the Council include the Information and Research Branches and French Speaking Services. Council publications include the periodicals, Canadian Welfare and Bien-Etre Social Canadien, a directory of Canadian welfare services, pamphlets, and division bulletins.

The Canadian Diabetic Association. -- Formed in 1953 with headquarters in Toronto, the Association has approximately 20 branches in various parts of the country and a French language affiliate, Association du Diabete, in Quebec. The aim of the organization is to promote public education regarding diabetes and to assist diabetic sufferers. Several provincial branches operate summer camps for diabetic children and the Ontario Branch provides a diet-counselling service.

The Canadian Red Cross Society. -- Established in 1896 in Canada, the Society is affiliated with the International Red Cross and has branches in all ten provinces with a national headquarters in Toronto. Its objectives, defined in its Charter, are ". . . in time of peace or war to carry on and assist in work for the improvement of health, the prevention of disease

and the mitigation of suffering throughout the world". Its activities cover a very broad area, ranging from national and international disaster relief services to the support of local projects. One of its major activities in Canada, the operation of a national blood transfusion service, collecting and supplying free of charge, for hospital use, blood provided by voluntary donors. The Society also maintains outpost hospitals, nursing stations and emergency units in several provinces. The Junior Red Cross promotes health education through its schoolroom branches across Canada; it supports a special fund to supply treatment to indigent handicapped children in Canada and a fund to promote understanding amongst school children of different countries.

The Canadian Foundation for Poliomyelitis and Rehabilitation. -- The Canadian Foundation for Poliomyelitis was formed in 1948 to assist victims of poliomyelitis but, because of the protection offered from Salk vaccine, the Foundation in 1958 broadened its aims and changed its name to the Canadian Foundation for Poliomyelitis and Rehabilitation. Provincial chapters in all ten provinces conduct an annual March of Dimes campaign to raise funds for the support of various rehabilitation projects; these include financial support to treatment centres for the disabled and direct services such as assistance in meeting the cost of medical and related services for needy disabled persons; in some provinces direct services are confined to those for adults. The Foundation, particularly in 1959, has also lent its support to the operation of clinics for immunization against poliomyelitis.

Victorian Order of Nurses* -- Since its inception in 1897, the Victorian Order of Nurses has provided a professional home nursing and health counselling service. In all provinces except Prince Edward Island, the association's nurses carry out bedside nursing, prenatal, postnatal and newborn care. In some provinces they also assist provincial health authorities in tuberculosis and venereal disease programs and conduct child health clinics. In 1958 the Order employed 642 nurses to serve in 120 branches located in nine provinces. The national office is in Ottawa.

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* A more complete picture of visiting nursing services of the Order may be found in the 1957-58 Year Book, pp. 269-270.

The Canadian National Institute for the Blind. -- Since its inception in 1918 the Canadian National Institute for the Blind has been dedicated to the provision of rehabilitation and social welfare services to the blind and to those with partial sight. The national office, located in Toronto, serves all provinces through its seven regional divisions and 46 branches. The Institute provides both social services and financial assistance; it arranges for examinations and eye treatment services, purchases glasses for needy persons and, in co-operation with hospitals and medical centres, operates an eye-bank. Under an extensive rehabilitation program with training facilities centred in Toronto, it trains blind persons in various occupations, offers job counselling and placement services and, for those who cannot compete in industry, it provides sheltered workshops; its more than 425 newspaper, tobacco and confectionery concession stands are operated by blind persons. Sightless field workers bring a home-training program to blind persons to help them learn Braille, typing and handicrafts, and a special program for pre-school blind children prepares them for attendance at a school for the blind. The Institute builds and maintains residential quarters and recreational facilities in all larger centres and supplies Braille books and recordings to the blind from its national library in Toronto.

The Health League of Canada. -- The Health League of Canada, first established in 1918 as a National Committee for Combating Venereal Disease, now embraces about sixty national member associations supporting a wide variety of health activities. The primary objectives of the League are the promotion of personal and community health and the prevention of disease through health education. Its major activities are administered from a national office in Toronto, usually working through the affiliated organizations. Educational efforts include the provision of speakers for meetings and the preparation of radio scripts, health education films and literature; a magazine is published bi-monthly and weekly news bulletins are released to the press. The League also sponsors a National Health Week and a National Immunization Week.

St. John Ambulance Association. -- The Order of the Hospital of St. John of Jerusalem began as a local unit in Montreal in 1884. The organization is composed of two parts, the St. John Ambulance Association and the St. John Ambulance Brigade. The first is devoted to teaching first aid and home nursing and the latter to directing the emergency corps of trained personnel. Headquarters of the Association is in Ottawa, with provincial divisions in all provinces controlling their own programs and financing the operation of their local branches.

The Canadian Tuberculosis Association. -- Founded in 1900 to stimulate public demand for increased treatment facilities, the Association has extended its objectives to case-finding, diagnostic services, rehabilitation of ex-patients and public education. Close co-operation exists with departments of health in the areas of case-finding and rehabilitation. Provincial organizations, which exist in all provinces, are largely autonomous, with the national office in Ottawa acting as a co-ordinating agency for the distribution of publicity material and as an advisory body to government agencies as well as to the provincial and local branches. The Association and its provincial bodies are supported by the sale of Christmas seals, with federal and provincial governments providing grants for specific projects.

The National Cancer Institute of Canada. -- The National Cancer Institute, composed of persons representing professional societies and agencies concerned with cancer research and therapy, was founded in 1947 to develop a nationally co-ordinated research and professional education program. The Institute promotes fundamental research through selected projects in universities, hospitals and research centres, maintains a Canadian Tumour Registry, provides training fellowships and, in cooperation with the Canadian Medical Association and medical schools, promotes professional education on cancer topics. The Institute receives support from federal and provincial grants and from the Canadian Cancer Society; a special project on lung cancer has been supported by the Canadian Tobacco Industry.

The Canadian Hearing Society. -- Organized in Toronto in 1940 as the National Society of the Deaf and the Hard of Hearing, the Society operates chiefly in Toronto and the surrounding area. It is concerned with the preservation of hearing, the treatment of deafness and the provision of rehabilitation services for those with impaired hearing. It provides otological examinations, counselling, vocational guidance and job placement services for the deaf or hard of hearing, and hearing aids to indigent persons.

The Canadian Mental Health Association. -- The Association, organized in 1918 as the National Committee for Mental Hygiene, now has divisions in nine provinces. Since its inception the organization has participated directly or indirectly in almost every development in the mental health field in Canada. The Association conducts an active public education program, serves as consultant to government departments, welfare agencies and voluntary organizations, operates a teacher training program and encourages research. Volunteer workers provide a variety of services related to the welfare of discharged and hospitalized mental patients. The national office at Toronto is supported by voluntary donations and federal and provincial grants.

The Canadian Cancer Society. -- Organized in 1938 to co-ordinate voluntary activities and disseminate knowledge in the cancer field, the Canadian Cancer Society operates in all provinces and has its national office in Toronto. Its services include a public education program, welfare services such as transportation, home nursing and cancer dressings to needy persons, and fellowships to medical graduates for advanced study in cancer. Voluntary subscriptions to the Society provide the major source of funds for the basic research program of the National Cancer Institute of Canada. The Society also supports clinical research.

National Heart Foundation of Canada. -- The Canadian Heart Foundation, formed in 1947 by physicians to co-ordinate research and disseminate information, was replaced by the National Heart Foundation of Canada in 1956. Its membership consists of lay and medical organizations interested in promoting or assisting research on cardiovascular diseases. Support for research projects comes from national and provincial grants and from private donations. The Foundation's national office is in Toronto; provincial branches have been established in eight provinces.

The Canadian Paraplegic Association. -- The Canadian Paraplegic Association, which was established in 1945 to complement the specialized treatment and rehabilitation services developed for veterans by the Department of Veterans Affairs, now includes services for civilian paraplegic cases and persons seriously handicapped by poliomyelitis and other disabling conditions. The national office of the Association and the major treatment centre, Lyndhurst Lodge, are housed in the same building in Toronto, Ont. Services include in-patient and out-patient therapy, the provision of prosthetic appliances, loans to patients, and rehabilitation services such as job counselling. Four regional divisions also have been established. The British Columbia Division is affiliated with the G.F. Strong Rehabilitation Centre in Vancouver.

The Canadian Council for Crippled Children and Adults. -- The Council was established in 1937 to co-ordinate and support activities for the care and rehabilitation of physically impaired children. The first provincial organization was formed in Ontario in 1922 and similar organizations, which have remained autonomous, now exist in all provinces. In 1954 the services of the organization were extended to include adults. Programs in the provinces vary, ranging from the establishement of cerebral palsy clinics and the operation of summer camps for the handicapped, to payment for treatment services, prosthetics, and hospital and nursing care for needy handicapped persons. In most provinces, service clubs raise funds to support the work of the organization, particularly through the sale of Easter Seals.

The Canadian Arthritis and Rheumatism Society. -- Established in 1948 to promote research, professional education and treatment services in the field of rheumatism and arthritis and to disseminate factual information, the Society has branches operating in all provinces except Prince Edward Island and Newfoundland; its national office is in Toronto, Ont. Medical advisory boards in each of the eight provinces and one at the national level give advice and guidance to the provincial and national directors. The Society sponsors an education program both for the general public and for physicians and maintains out-patient clinics in general hospitals for the treatment of low-income patients. Its branches pioneered in the operation of mobile clinics and now operate some seventy units to bring treatment to home-bound patients and in three provinces support a mobile consultative service. All divisions have a liaison with employment agencies and vocational training schemes. Services are usually free or for a nominal amount. The national body promotes research projects in various universities and institutions and provides clinical fellowships to physicians in all parts of Canada.

Multiple Sclerosis Society of Canada. -- Organized in 1948 to encourage, support and co-ordinate research regarding multiple sclerosis, the Society also compiles statistics and carries on public education. The national office in Ottawa is maintained by nineteen provincial and local chapters whose chief function is fund-raising from which research projects are financed. Local chapters also help indigent persons to obtain wheelchairs, orthopedic supports and other necessary equipment.

The Canadian Association for Retarded Children. -- The Association was incorporated in 1958 to assist and give co-ordinated direction to the work of a growing number of organizations for the mentally retarded now represented by 10 provincial and some 130 local groups. Membership of the locals exceeds 12,000, most of whom are parents of mentally retarded children. The Association promotes the establishment of clinics, day schools, institutions and workshops; it also supports and encourages research into the causes of mental deficiency. Increasing numbers of day classes offer training opportunities within the community for mentally retarded children who are not acceptable for regular school instruction. Financial support comes from local fund-raising campaigns, community chests and, in varying degrees, from provincial departments of education.

The Muscular Dystrophy Association of Canada. -- This Association was organized in 1954 to stimulate and unify efforts in research into the cause, nature and cure of muscular dystrophy and to promote the establishment of facilities for diagnostic, consultative and treatment services. It has a national office in Toronto supported by nine regional chapters and its chief activity is the support of research projects in medical centres across the country. Individuals suffering from muscular dystrophy may also receive assistance in the purchase of items such as necessary equipment and in obtaining transportation to clinics.